

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 5 to be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04067

04063

1. PLACE OF DEATH a. COUNTY M ANNE ARUNDEL MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) ANNAPOLIS		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) ANNAPOLIS	
c. LENGTH OF STAY IN 1b 19 DAYS		d. STREET ADDRESS 111 ARCH WOOD AVENUE	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U.S. NAVAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MAX THEODORE BACHMANN		4. DATE OF DEATH Month Day Year APRIL 8 1962	
5. SEX MALE	6. COLOR OR RACE CAUC	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/7/75
9. AGE (In years last birthday) 87 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MUC		10b. KIND OF BUSINESS OR INDUSTRY USN RET	11. BIRTHPLACE (County & State, or foreign country) GERMANY
13. FATHER'S NAME UNKNOWN		14. MOTHER'S MAIDEN NAME ALBANI WEISEBACH (DEC)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) YES 1911 - 1933		16. SOCIAL SECURITY NO. NONE	17. INFORMANT Address GEORGE T. BACHMANN, 111 ARCH WOOD AVE. (2)
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC STANDSTILL - 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) ARTERIOSCLEROTIC HEART DISEASE, (e), stating the underlying cause last. (c) DAMAGED MYOCARDIUM + A.F. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) URINARY RETENTION - BENIGN PROSTATIC HYPERTROPHY			INTERVAL BETWEEN ONSET AND DEATH 10 MIN. 10 YRS ±
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 28 MARCH 1962 to 8 APRIL 1962 that (I) (we) last saw the deceased alive on 8 APRIL 1962 and that death occurred at 7:15 P.M. from the causes and on the date stated above.			
22a. SIGNATURE EC Reece M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED 8 APRIL 62
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Apr 11 - 1962	23c. NAME OF CEMETERY OR CREMATORY Cedar Bluff Cent	23d. LOCATION (City, town or county) (State) Annapolis Md
24. FUNERAL DIRECTOR'S SIGNATURE John M. Saylor Sins		ADDRESS Annapolis Md	25a. REC'D BY REGISTRAR DATE APR 12 '62
		25b. REGISTRAR'S SIGNATURE Arthur S. Huns	

01003

CERTIFICATE OF DEATH

1961

NAME SURVIVOR

NAME DECEASED

DATE

PLACE

RELATIONSHIP

AGE

SEX

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

RELIGION

BY

DATE

PLACE

USA

DATE

PLACE

DATE

DATE OF DEATH

PLACE

NAME OF DECEASED

DATE

PLACE

10 min

CHORDS STIMULATED

HEART DISEASE, 10 min

MYOCARDIUM - A.F.

CHORDS STIMULATED

DATE OF DEATH

DATE

8 min 10

X

ST. Louis

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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04068

04064

Items 18 & 21, Film G-512 57762.cac

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SHADYSIDE		c. LENGTH OF STAY in 1b 76 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Shadyside		d. STREET ADDRESS 1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First HENRY Middle E/SWORTH Last BAST				4. DATE OF DEATH Month April Day 19 Year 1962			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-9-1885	9. AGE (In years last birthday) 76 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman		10b. KIND OF BUSINESS OR INDUSTRY Sea Food		11. BIRTHPLACE (State or foreign country) Shadyside Md		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Richard Bast				14. MOTHER'S MAIDEN NAME Erishah Woodfield			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 214-24-2935		17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease with Old Pulmonary Emphysema. 420.0 XXXX Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		2Db. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Charles S. Petty M.D.				DATE SIGNED 4/19/62			
EXAMINER'S NAME (Type) Charles S. Petty, M.D.				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 4-21-62			
22c. NAME OF CEMETERY OR CREMATORY Greenwood Cemetery				22d. LOCATION (City, town, or country) (State) Wadesville Md.			
23. FUNERAL DIRECTOR Greenwood Mortuary				24a. REC'D BY REGISTRAR APR 24 '62			
ADDRESS Wadesville Md				24b. REGISTRAR'S SIGNATURE Arthur L. Kinn			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 2 should be retained by the hospital or attending physician. Page 2 of 2 should be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04069 CERTIFICATE OF DEATH 04065

1. PLACE OF DEATH a. COUNTY A.A.C.O. b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Glen Burnie c. LENGTH OF STAY IN TB 3 yrs d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Glen Burnie 906 Rose Anne Rd		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY Anne Arundel c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Glen Burnie A.A. Co. d. STREET ADDRESS 906 Rose Anne Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) LOUIS First (WHITE) BIALORZYSKI Middle Last 4. DATE OF DEATH April 24, 1962		5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH Oct. 1890 9. AGE (In years last birthday) 71 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Paint sprayer 10b. KIND OF BUSINESS OR INDUSTRY Steam Boilers Balto. Md. 11. BIRTHPLACE (County & State, or foreign country) W. S. A. 12. CITIZEN OF WHAT COUNTRY		13. FATHER'S NAME Laurance Bialorzynski 14. MOTHER'S MAIDEN NAME Jozefar	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) — (If yes give year or dates of service) 16. SOCIAL SECURITY NO. 216-10-8834 17. INFORMANT Antoni Bialorzynski Address 906 Rose Anne Rd.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 Congestive Heart Failure DUE TO Pet. sclerotic Heart Disease Cardio-vascular Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from 4-6-1962 to 4-24-1962 that (I) (we) last saw the deceased alive on 4-19-1962 , and that death occurred at 11 P.M. from the causes and on the date stated above.	
22a. SIGNATURE Ignas Saulynas 22c. PHYSICIAN'S NAME (Type) IGNAS SAULYNAS 22d. ADDRESS 319 Old Annapolis Rd		22b. DATE SIGNED 4-24-1962 ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 4/28/62 23c. NAME OF CEMETERY OR CREMATORY Hol. St. Stanislaus 23d. LOCATION (City, town or county) (State) Balto. Co. Md		24. FUNERAL DIRECTOR'S SIGNATURE Wm. S. Fialkowski ADDRESS 2007 Eastern Ave 25. REC'D BY REGISTRAR DATE APR 26 '62 25b. REGISTRAR'S SIGNATURE Arthur S. H...	

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VR A15 (4)
15M 7/61

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
04070					04066				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)				
a. COUNTY Anne Arundel					a. STATE Maryland				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) RURAL					b. COUNTY Anne Arundel				
c. LENGTH OF STAY IN 1b 60 yrs.					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) RURAL				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) DEALE P.O.					d. STREET ADDRESS DEALE P.O.				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print)			First Middle Last			4. DATE OF DEATH		Month Day Year	
LOUISE JANE HARRIS BIAS						April 26		19 62	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 18-1872		9. AGE (In years last birthday) 89 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY *****		11. BIRTHPLACE (County & State, or foreign country) Anne Arundel Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Wesley Harris			14. MOTHER'S MAIDEN NAME Lucy ?						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No			16. SOCIAL SECURITY NO. None		17. INFORMANT Address Marv Mimr-4626 Clav St. Wash. 19-D.C. N.E.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Generalized arteriosclerosis & arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) arteriosclerotic heart disease INTERVAL BETWEEN ONSET AND DEATH Immediate year									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL CONDITION GIVEN IN PART I (a):									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from Jan 19 60 to April 26, 1962 ; that (I) (the) last saw the deceased alive on March 20, 1962 , and that death occurred at 27 P.M. from the causes and on the date stated above.									
22a. SIGNATURE Willard F. Smith			M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 4/28/62		
22c. PHYSICIAN'S NAME (Type) WILLARD F. SMITH			22d. ADDRESS Shady Side, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF Apr. 29-62		23c. NAME OF CEMETERY OR CREMATORY UNION CHAPEL		23d. LOCATION (City, town or county) (State) McKendree, Maryland		
24. FUNERAL DIRECTOR'S SIGNATURE C.E. Hicks III					ADDRESS Annamolis, Maryland		25a. REC'D BY REGISTRAR MAY 2 '62		25b. REGISTRAR'S SIGNATURE Arthur S. Thomas

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04071

04067

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville c. LENGTH OF STAY in 1b 26 years 9 mos. 7 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Crownsville State Hospital		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) South River d. STREET ADDRESS ? e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Jeremiah Blake		4. DATE OF DEATH Month Day Year 4 18 1962	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/4/14
9. AGE (In years last birthday) yrs. 47		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm-Hand	11. BIRTHPLACE (County & State, or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Charlie Blake		14. MOTHER'S MAIDEN NAME Carrie ?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO Arteriosclerotic Cardiovascular Disease (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Brain Syndrome			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----	
20c. TIME OF INJURY Month, Day, Year Hour e.m. ----- p.m. 19		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State) 4/20 19 34 to 4/18 19 62 , that (I) (we) last saw the deceased alive on 4/18 19 62 , and that death occurred at 3:30 P. from the causes and on the date stated above.	
21. I certify that (I) (this hospital) attended the deceased from 4/18 1962 , that (I) (we) last saw the deceased alive on 4/18 1962 , and that death occurred at 3:30 P. from the causes and on the date stated above.			
22a. SIGNATURE Hildegard Heard Reissman M.D.		22b. DATE SIGNED 4/18/62	
22c. PHYSICIAN NAME (Type) Hildegard Heard Reissman, M. D.		22d. ADDRESS Crownsville State Hospital, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-21-62	
23c. NAME OF CEMETERY OR CREMATORY mtf bury		23d. LOCATION (City, town or county) (State) md	
24. FUNERAL DIRECTOR'S SIGNATURE 209 S. Nelson 1348 N. Calhoun St		25a. REC'D BY REGISTRAR DATE APR 23 '62	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

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CERTIFICATE OF DEATH

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Medical Records

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Germany, Prussia

Attention: North American War Service

Genetic Brain Systems

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 **MARYLAND STATE DEPARTMENT OF HEALTH****DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

04072

CERTIFICATE OF DEATH

04068

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>				c. LENGTH OF STAY IN 1b <u>Crownsville</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Waterbury Road</u>				d. STREET ADDRESS <u>Waterbury Road Box 104</u>			
3. NAME OF DECEASED (Type or print) First <u>HOWARD</u> Middle <u>E.</u> Last <u>BOYER</u>				4. DATE OF DEATH Month <u>April</u> Day <u>11th</u> Year <u>1962</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>22nd. Sept. '75</u>	
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer (ret.)</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Self-Employed</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Anne Arundel Co., Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Albert Boyer</u>				14. MOTHER'S MAIDEN NAME <u>Annie Shipley</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give year or dates of service) <u>none</u>				16. SOCIAL SECURITY NO. <u>none</u>			
17. INFORMANT <u>Mr. Burton Boyer</u>				Address <u>Glen Burnie, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>422.1</u> IMMEDIATE CAUSE (a) <u>Pneumonitis Generalized</u> DUE TO (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u>Sclerotic Cardiovascular Disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>Today -</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>			
20c. TIME OF INJURY Month, Day, Year <u>Hour a.m.</u> <u>19</u> p.m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> el work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>							
21. I certify that (I) (this hospital) attended the deceased from <u>June 1960</u> to <u>April 11, 1962</u> that (I) (we) last saw the deceased alive on <u>April 11, 1962</u> and that death occurred at <u>11 A.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Felix Grunberg</u>				22b. DATE SIGNED <u>4/13/62</u>			
22c. PHYSICIAN'S NAME (Type) <u>Felix Grunberg</u>				22d. ADDRESS <u>609 Odenton Rd. Odenton</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>14th April '62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Baldwin Mem. Ch. Cem.</u>		23d. LOCATION (City, town or county) <u>Millersville, Maryland</u> (State) <u> </u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>L. V. Dignall</u>				25a. REC'D BY REGISTRAR <u>Glen Burnie, Md.</u>			
25b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>				DATE <u>APR 16 '62</u>			

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

04069

STATE DEPARTMENT OF HEALTH
OFFICE of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 7 Film G313 6/22/62 iwk

04069

1. PLACE OF DEATH a. COUNTY Anne Arundel				b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severn				c. LENGTH OF STAY IN lb 2 months				2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE Same b. COUNTY Same c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Same d. STREET ADDRESS Same				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
3. NAME OF DECEASED (Type or print) Donald Earl Braden				4. DATE OF DEATH Month April Day 17 Year 1962				5. SEX M				6. COLOR OR RACE W				7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH 6/14/08				9. AGE (In years last birthday) 53 yrs.				10. IF UNDER 1 YEAR Months 0 Days 0				11. IF UNDER 24 HRS. Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Insurance agent.				10b. KIND OF BUSINESS OR INDUSTRY Insurance agent.				11. BIRTHPLACE (State or foreign country) PENNSYLVANIA				12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME Robert Braden				14. MOTHER'S MAIDEN NAME ?															
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) NO				16. SOCIAL SECURITY NO. 209-09-3715				17. INFORMANT Mrs Mary Knoer, 9th St. Turtle Creek PA.				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 420 DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH Sudden																			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED 4/17/62																			
ACTUAL SIGNATURE Gustave H. Faubert				EXAMINER'S NAME (Type) Gustave H. Faubert, M.D.				Address (Street, city, town, or county) Glen Burnie, Md.				22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 4/21/62				22c. NAME OF CEMETERY OR CREMATORY Union Cemetery				22d. LOCATION (City, town, or country) (State) LATROBE PA.											
23. FUNERAL DIRECTOR Hopping & KIRKLEY				ADDRESS Glen Burnie, Md.				24a. REC'D BY REGISTRAR APR 23 '62				24b. REGISTRAR'S SIGNATURE Arthur S. Kline																							

MEDICAL CERTIFICATION

65926

1
FOR STATE
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04074 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 04070

1. PLACE OF DEATH a. COUNTY Anne Arundel		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Pasadena, Lake Shore		c. LENGTH OF STAY IN 1b 29 Yrs	
2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Same Maryland		b. COUNTY Same Anne Arundel		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) X Same Pasadena, Lake Shore	
3. NAME OF DECEASED (Type or print) First Middle Last Frederick F. Brock		d. STREET ADDRESS Same Pasadena P O		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
4. DATE OF DEATH Month Day Year April 7th (Sat) 1962		5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/27/94		9. AGE (In years birth day) yrs. 68	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic (Ret)		10b. KIND OF BUSINESS OR INDUSTRY Beth. Ship Repair YD.		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Henry Brock		14. MOTHER'S MAIDEN NAME Anna Klugg (KRUG)	
15. WAS DECEASED EVER IN U.S. ARMED SERVICES? (Yes, no, or unknown) (If yes give war or service) Yes 8/17/18 LW War. 19		16. SOCIAL SECURITY NO. 212-10-1291-A		17. INFORMANT Mrs. Bessie E. Brock (Wife) Mrs. F.F. Brock (wife) SAME ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 4-20-1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH Sudden			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Gustave H. Faubert, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 4/8/62	
EXAMINER'S NAME (Type) Gustave H. Faubert, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Wed. Apr. 11, 1962		22c. NAME OF CEMETERY OR CREMATORY Balto. U.S. Nat'l. Cem.	
22d. LOCATION (City, town, or country) Baltimore 28, Maryland		22e. (State) Maryland		22f. (Country)	
23. FUNERAL DIRECTOR A. HOWARD EVANS		ADDRESS Curtis E. Evans 1400 S. Charles St. 30, Md.		24a. REC'D BY REGISTRAR DATE APR 10 '62	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus					

VS. A15ME
5M 9/60

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01010

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THE
OFFICE
OF THE
ATTORNEY GENERAL
STATE OF NEW YORK
ALBANY
JANUARY 10, 1901
TO THE
COMMISSIONER OF THE LAND OFFICE
SIR:
I have the honor to acknowledge the receipt of your letter of the 7th inst. in relation to the application of the State of New York for the purchase of the land owned by the State of New York, and in reply to inform you that the same has been referred to the proper authorities for their consideration.
Very respectfully,
J. B. ALLEN, Attorney General.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04075

04071

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Waterbury	
c. LENGTH OF STAY IN lb 5 days		d. STREET ADDRESS 1	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Anne Arundel General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First George Middle BROOKS Last BROOKS		4. DATE OF DEATH Month April Day 28 Year 1962	
5. SEX Male		6. COLOR OR RACE Negro	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 7, 1913	
9. AGE (In years last birthday) 48 yrs.		10. IF UNDER 1 YEAR Months 4 Days 28	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Thomas Brooks		14. MOTHER'S MAIDEN NAME Ethel Osborne	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 217-030515	
17. INFORMANT Christine Brooks Crownsville		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 493 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral hemorrhage	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. INTERVAL BETWEEN ONSET AND DEATH 36 hrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. 11:45 p.m. AM		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) the deceased attended the deceased from Apr. 23, 1962 to Apr. 28, 1962 , that (I) 320 last saw the deceased alive on Apr. 28, 1962 , and that death occurred at 11:45 AM , from the causes and on the date stated above.			
22a. SIGNATURE G. Church		22b. DATE SIGNED 4/30/62	
22c. PHYSICIAN'S NAME (Type) Gerard Church, M.D.		22d. ADDRESS 121 Cathedral St., Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-1-1962	
23c. NAME OF CEMETERY OR CREMATORY Mt. Tabor		23d. LOCATION (City, town or county) (State) Chesterfield Md.	
24. FUNERAL DIRECTOR'S SIGNATURE William Reese Jr. Annapolis, Md.		25a. REC'D BY REGISTRAR MAY 2 '62	
25b. REGISTRAR'S SIGNATURE Arthur S. Hines			

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No 040722

04076

1. PLACE OF DEATH a. COUNTY <u>A. A.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A. A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN 1b <u>10</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>145 Besgate Road</u>				d. STREET ADDRESS <u>145 Besgate Road</u>			
3. NAME OF DECEASED (Type or print) <u>Alvin</u> First <u>Brown</u> Middle <u>Brown</u> Last				4. DATE OF DEATH Month <u>4</u> Day <u>17</u> Year <u>1962</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Col</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-10-1960</u>	
9. AGE (In years, months, and days) <u>2</u> yrs.		IF UNDER 1 YEAR Months <u>4</u> Days <u>17</u>		IF UNDER 24 HRS. Hours <u>17</u> Min. <u>1962</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Chas Brown Jr.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Chas Brown Jr.</u> Address <u>145 Besgate Rd</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Third degree Burns</u> DUE TO <u>916.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Sudden</u> DUE TO (c) <u>Sudden</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Stove blew up</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Stove blew up</u>			
20c. TIME OF INJURY Month, Day, Year <u>Apr. 17 62</u> Hour <u>3:00</u> a. m. <input checked="" type="checkbox"/> p. m. <input type="checkbox"/>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>home</u>		20f. (City or town) <u>A. A.</u> (County) <u>Md.</u> (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Michael E. L. Wharff</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>E. L. Wharff</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-20-62</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Faulkner</u>		22d. LOCATION (City, town, or county) <u>Adenton Md</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese Jr.</u> ADDRESS <u>Anna Md</u>				24a. REC'D BY REGISTRAR <u>DATE APR 24 '62</u>		24b. REGISTRAR'S SIGNATURE <u>Robert S. Harris</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

04077

Reg. Dis. No. 073

1. PLACE OF DEATH o. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		a. STATE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		b. COUNTY	
c. LENGTH OF STAY IN TB		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
First Middle Last		Month Day Year	
5. SEX		6. COLOR OR RACE	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH	
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR Months Days	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 916.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Stove blew up	
20c. TIME OF INJURY Month, Day, Year Hour o. m. x 3000 Apr. 17 1962		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home		20f. (City or town) (County) (State) A.A. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED 477-62			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR	
ADDRESS		24b. REGISTRAR'S SIGNATURE	
DATE		APR 24 '62	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON 10
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6-17-77

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF EXAMINER	
13. SIGNATURE OF ATTENDING PHYSICIAN		14. SIGNATURE OF CORONER		15. SIGNATURE OF JURY	
16. SIGNATURE OF WITNESSES		17. SIGNATURE OF FUNERAL HOME		18. SIGNATURE OF CHURCH	
19. SIGNATURE OF MINISTERS		20. SIGNATURE OF OTHERS		21. SIGNATURE OF OTHERS	
22. SIGNATURE OF OTHERS		23. SIGNATURE OF OTHERS		24. SIGNATURE OF OTHERS	
25. SIGNATURE OF OTHERS		26. SIGNATURE OF OTHERS		27. SIGNATURE OF OTHERS	
28. SIGNATURE OF OTHERS		29. SIGNATURE OF OTHERS		30. SIGNATURE OF OTHERS	
31. SIGNATURE OF OTHERS		32. SIGNATURE OF OTHERS		33. SIGNATURE OF OTHERS	
34. SIGNATURE OF OTHERS		35. SIGNATURE OF OTHERS		36. SIGNATURE OF OTHERS	
37. SIGNATURE OF OTHERS		38. SIGNATURE OF OTHERS		39. SIGNATURE OF OTHERS	
40. SIGNATURE OF OTHERS		41. SIGNATURE OF OTHERS		42. SIGNATURE OF OTHERS	
43. SIGNATURE OF OTHERS		44. SIGNATURE OF OTHERS		45. SIGNATURE OF OTHERS	
46. SIGNATURE OF OTHERS		47. SIGNATURE OF OTHERS		48. SIGNATURE OF OTHERS	
49. SIGNATURE OF OTHERS		50. SIGNATURE OF OTHERS		51. SIGNATURE OF OTHERS	
52. SIGNATURE OF OTHERS		53. SIGNATURE OF OTHERS		54. SIGNATURE OF OTHERS	
55. SIGNATURE OF OTHERS		56. SIGNATURE OF OTHERS		57. SIGNATURE OF OTHERS	
58. SIGNATURE OF OTHERS		59. SIGNATURE OF OTHERS		60. SIGNATURE OF OTHERS	
61. SIGNATURE OF OTHERS		62. SIGNATURE OF OTHERS		63. SIGNATURE OF OTHERS	
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67. SIGNATURE OF OTHERS		68. SIGNATURE OF OTHERS		69. SIGNATURE OF OTHERS	
70. SIGNATURE OF OTHERS		71. SIGNATURE OF OTHERS		72. SIGNATURE OF OTHERS	
73. SIGNATURE OF OTHERS		74. SIGNATURE OF OTHERS		75. SIGNATURE OF OTHERS	
76. SIGNATURE OF OTHERS		77. SIGNATURE OF OTHERS		78. SIGNATURE OF OTHERS	
79. SIGNATURE OF OTHERS		80. SIGNATURE OF OTHERS		81. SIGNATURE OF OTHERS	
82. SIGNATURE OF OTHERS		83. SIGNATURE OF OTHERS		84. SIGNATURE OF OTHERS	
85. SIGNATURE OF OTHERS		86. SIGNATURE OF OTHERS		87. SIGNATURE OF OTHERS	
88. SIGNATURE OF OTHERS		89. SIGNATURE OF OTHERS		90. SIGNATURE OF OTHERS	
91. SIGNATURE OF OTHERS		92. SIGNATURE OF OTHERS		93. SIGNATURE OF OTHERS	
94. SIGNATURE OF OTHERS		95. SIGNATURE OF OTHERS		96. SIGNATURE OF OTHERS	
97. SIGNATURE OF OTHERS		98. SIGNATURE OF OTHERS		99. SIGNATURE OF OTHERS	
100. SIGNATURE OF OTHERS		101. SIGNATURE OF OTHERS		102. SIGNATURE OF OTHERS	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 04074

04078

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel Co</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Glen Burnie</i> b. COUNTY <i>A. A. Co</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Glen Burnie</i>	c. LENGTH OF STAY IN 1b <i>30 years</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X Glen Burnie</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>205 - Second Ave., S.W.</i>		d. STREET ADDRESS <i>205 2nd Ave Glen Burnie</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <i>Herman</i> Middle <i>Frank</i> Last <i>Brown</i>		4. DATE OF DEATH Month <i>April</i> Day <i>3</i> Year <i>1962</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept 26, 1881</i>
9. AGE (In years last birthday) <i>80 yrs.</i>		IF UNDER 1 YEAR Months <i>-</i> Days <i>-</i> Hours <i>-</i> Min. <i>-</i>	IF UNDER 24 HRS. Hours <i>-</i> Min. <i>-</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Clerk at Smith Co.</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Lumbering</i>	11. BIRTHPLACE (State or foreign country) <i>A. A. Co. Maryland.</i>
12. CITIZEN OF WHAT COUNTRY? <i>U. S. A</i>		13. FATHER'S NAME <i>Frank Harrison Brown</i>	
14. MOTHER'S MAIDEN NAME <i>Sarah Stollings</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <i>215-01-6694</i>		17. INFORMANT <i>Mr. Walter Solley</i> Address <i>205 2nd Ave Glen Burnie</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i> <i>422</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Cardio-Vascular Disease</i> DUE TO (c) <i>None</i>			INTERVAL BETWEEN ONSET AND DEATH <i>48 hours</i> <i>3 years</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>None</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <i>19</i> p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Jan</i> , 19 <i>59</i> , to <i>April 3</i> , 19 <i>62</i> , that I last saw the deceased alive on <i>April 2</i> , 19 <i>62</i> , and that death occurred at <i>7:50</i> A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>James S. Billingslee</i>		ADDRESS (Street, city or town, state) DATE SIGNED <i>108 Cedar Ave Glen Burnie Md 11/3/62</i>	
PHYSICIAN'S NAME (Type) <i>James S. Billingslee</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <i>63 Apr 1962</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Mt. Carmel Ch. Cem.</i>	22d. LOCATION (City, town, or county) (State) <i>Lake Shore, Pasadena, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Richard V. Anglin</i>		ADDRESS <i>Glen Burnie, Md.</i>	24a. REC'D BY REGISTRAR <i>DATE APR 5 '62</i>
		24b. REGISTRAR'S SIGNATURE <i>Arthur J. Herring</i>	

CERTIFICATE OF DEATH

1907

<p>1. Name of deceased</p>		<p>2. Sex</p>		<p>3. Age</p>		<p>4. Date of birth</p>	
<p>5. Place of birth</p>		<p>6. Usual residence</p>		<p>7. Date of death</p>		<p>8. Time of death</p>	
<p>9. Cause of death</p>		<p>10. Nature of disease</p>		<p>11. Duration of disease</p>		<p>12. Place of death</p>	
<p>13. Name of physician</p>		<p>14. Name of attending physician</p>		<p>15. Name of medical examiner</p>		<p>16. Name of coroner</p>	
<p>17. Name of funeral home</p>		<p>18. Name of undertaker</p>		<p>19. Name of cemetery</p>		<p>20. Name of burial place</p>	
<p>21. Name of informant</p>		<p>22. Name of informant</p>		<p>23. Name of informant</p>		<p>24. Name of informant</p>	
<p>25. Name of informant</p>		<p>26. Name of informant</p>		<p>27. Name of informant</p>		<p>28. Name of informant</p>	
<p>29. Name of informant</p>		<p>30. Name of informant</p>		<p>31. Name of informant</p>		<p>32. Name of informant</p>	
<p>33. Name of informant</p>		<p>34. Name of informant</p>		<p>35. Name of informant</p>		<p>36. Name of informant</p>	
<p>37. Name of informant</p>		<p>38. Name of informant</p>		<p>39. Name of informant</p>		<p>40. Name of informant</p>	
<p>41. Name of informant</p>		<p>42. Name of informant</p>		<p>43. Name of informant</p>		<p>44. Name of informant</p>	
<p>45. Name of informant</p>		<p>46. Name of informant</p>		<p>47. Name of informant</p>		<p>48. Name of informant</p>	
<p>49. Name of informant</p>		<p>50. Name of informant</p>		<p>51. Name of informant</p>		<p>52. Name of informant</p>	
<p>53. Name of informant</p>		<p>54. Name of informant</p>		<p>55. Name of informant</p>		<p>56. Name of informant</p>	
<p>57. Name of informant</p>		<p>58. Name of informant</p>		<p>59. Name of informant</p>		<p>60. Name of informant</p>	
<p>61. Name of informant</p>		<p>62. Name of informant</p>		<p>63. Name of informant</p>		<p>64. Name of informant</p>	
<p>65. Name of informant</p>		<p>66. Name of informant</p>		<p>67. Name of informant</p>		<p>68. Name of informant</p>	
<p>69. Name of informant</p>		<p>70. Name of informant</p>		<p>71. Name of informant</p>		<p>72. Name of informant</p>	
<p>73. Name of informant</p>		<p>74. Name of informant</p>		<p>75. Name of informant</p>		<p>76. Name of informant</p>	
<p>77. Name of informant</p>		<p>78. Name of informant</p>		<p>79. Name of informant</p>		<p>80. Name of informant</p>	
<p>81. Name of informant</p>		<p>82. Name of informant</p>		<p>83. Name of informant</p>		<p>84. Name of informant</p>	
<p>85. Name of informant</p>		<p>86. Name of informant</p>		<p>87. Name of informant</p>		<p>88. Name of informant</p>	
<p>89. Name of informant</p>		<p>90. Name of informant</p>		<p>91. Name of informant</p>		<p>92. Name of informant</p>	
<p>93. Name of informant</p>		<p>94. Name of informant</p>		<p>95. Name of informant</p>		<p>96. Name of informant</p>	
<p>97. Name of informant</p>		<p>98. Name of informant</p>		<p>99. Name of informant</p>		<p>100. Name of informant</p>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 shall be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
04079					04075									
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)									
a. COUNTY Anne Arundel					a. STATE Maryland									
b. COUNTY Maryland					b. COUNTY Baltimore City									
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore									
c. LENGTH OF STAY in 1b 18 days					d. STREET ADDRESS 1620 Millimor Street									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Crownsville State Hospital					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH									
First Middle Last William S Brown					Month Day Year 4 19 62									
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 26, 1894		9. AGE (In years last birthday) 67 yrs.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		IF UNDER 1 YEAR Months Days Hours Min.						
13. FATHER'S NAME James R. Brown					14. MOTHER'S MAIDEN NAME Adiline									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war and dates of service) Unknown					16. SOCIAL SECURITY NO. Unknown					17. INFORMANT Hospital Records				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Arteriosclerotic Hypertensive Cardiovascular Disease DUE TO (b) DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic Brain Syndrome due to Cerebral Arteriosclerosis														
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)														
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----														
20c. TIME OF INJURY Month, Day, Year Hour a.m. ----- p.m. 19														
20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>														
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 4/1														
20f. (City or town) (County) (State) 62 4/19 62														
21. I certify that (I) (this hospital) attended the deceased from 4/19 1962 , to 4/19 1962 , that (I) (we) last saw the deceased alive on 4/19 1962 , and that death occurred at 1:20 P.M. from the causes and on the date stated above.														
22a. SIGNATURE Lionel McHenry Napp, M. D.														
22b. DATE 4/19/62														
22c. PHYSICIAN'S NAME (Type) Lionel McHenry Napp, M. D.														
22d. ADDRESS Crownsville State Hospital, Maryland														
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL														
23b. DATE THEREOF 4/24/62														
23c. NAME OF CEMETERY OR CREMATORY Baltimore Nat'l Cem														
23d. LOCATION (City, town or county) (State) Cedar Hill, Md.														
24. FUNERAL DIRECTOR'S SIGNATURE C. O. Wilson														
24. ADDRESS 1000 Brnndy Ave.														
25a. REC'D BY REGISTRAR APR 27 '62														
25b. REGISTRAR'S SIGNATURE Arthur L. Hume														

04072

04073

1

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04080 CERTIFICATE OF DEATH 04076

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis c. LENGTH OF STAY IN IL 4 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Anne Arundel General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - Edgewater d. STREET ADDRESS Box-284 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Eleta KATHERINE BULL		4. DATE OF DEATH Month April Day 26 Year 1962	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 14, 1920
9. AGE (in years last birthday) 41 yrs.		10. IF UNDER 1 YEAR Months 5 months Days 3 1/2 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME	
11. BIRTHPLACE (County & State, or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME JACK SKILDING		14. MOTHER'S MAIDEN NAME GLADYS DYER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) —		16. SOCIAL SECURITY NO. VINTON T. BULL #2	
17. INFORMANT VINTON T. BULL		Address #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 171X Carcinomatosa DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) Carcinoma of Cervix DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH. 5 months 3 1/2 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (100000000) attended the deceased from June , 19 57 , to April 25 , 19 62 , that (I) (100) last saw the deceased alive on April 25 , 19 62 , and that death occurred at 12:35 AM from the causes and on the date stated above.			
22a. SIGNATURE James R. Martin		22b. DATE SIGNED 4/26/62	
22c. PHYSICIAN'S NAME (Type) James R. Martin		22d. ADDRESS 6 Shaw St., Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 4-29-62	23c. NAME OF CEMETERY OR CREMATORY MAYO MEMORIAL	23d. LOCATION (City, town or county) (State) MAYO Md.
24. FUNERAL DIRECTOR'S SIGNATURE John M. Laylor & Sons		25a. REC'D BY REGISTRAR MAY 1 '62	
ADDRESS Annapolis, Md.		25b. REGISTRAR'S SIGNATURE Charles E. Kenna	



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TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04081

CERTIFICATE OF DEATH

Reg. Dist. No. 04077

1. PLACE OF DEATH a. COUNTY <i>AA Co Md</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>AA Co</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Glen Burnie</i>		c. LENGTH OF STAY IN lb <i>25 yrs</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Charles B Burch</i> First Middle Last		4. DATE OF DEATH <i>April 6- 1962</i> Month Day Year	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan 28 - 1908</i>
9. AGE (In years last birthday) <i>54</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Builder</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Contractor</i>	
11. BIRTHPLACE (State or foreign country) <i>Essex Co Va</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Charles D Burch</i>		14. MOTHER'S MAIDEN NAME <i>Maggie Taylor</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>218-14-0854</i>	
INFORMANT <i>Mrs Mary Burch</i> Address <i>100 Wilson Blvd GB Md</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Renal Shuntation</i> DUE TO <i>Carburetor of Lungs with metastases</i> Conditions, if any which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) <i>one year</i> DUE TO (c) <i>one year</i>		INTERVAL BETWEEN ONSET AND DEATH <i>5 days</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>July</i> , 1961, to <i>April</i> , 1962, that I last saw the deceased alive on <i>April 4- 1962</i> , and that death occurred at <i>6:30 P.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>5 Central Ave.</i> DATE SIGNED <i>Glen Burnie Md.</i>			
ACTUAL SIGNATURE <i>Hilary T. O'Heir</i> M.D.			
PHYSICIAN'S NAME (Type) <i>HILARY T. O'HEIR</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>April 9-62</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Glen Haven Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Glen Burnie AA Co Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Raymond S. Fink</i> ADDRESS <i>Glen Burnie Md</i>		24a. REC'D BY REGISTRAR DATE <i>APR 9 '62</i>	
		24b. REGISTRAR'S SIGNATURE <i>Carroll S. Kline</i>	

04053

STATE OF TEXAS
COUNTY OF DALLAS

1903

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1 FOR STATE HEALTH DEPT. M 99 2 2 VS. AISM SM 9/60

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04082

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 7 Film G312 5/1/62 mh

04078

1. PLACE OF DEATH a. COUNTY Anne Arundel		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rose Haven Yacht Club		c. LENGTH OF STAY IN 1b 1705 Price Street		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE Virginia b. COUNTY 83x-3	
3. NAME OF DECEASED (Type or print) RUTH B. BURTON		4. DATE OF DEATH Month 4 Day 23 Year 1962		5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 7, 1915		9. AGE (In years last birthday) 46 yrs.		10. IF UNDER 1 YEAR Months 4 Days 23 Hours 1962	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ?		10b. KIND OF BUSINESS OR INDUSTRY ?		11. BIRTHPLACE (State or foreign country) ?		12. CITIZEN OF WHAT COUNTRY? ?	
13. FATHER'S NAME Ira Barton		14. MOTHER'S MAIDEN NAME Daisy Fadely		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. Demaine Funeral Home-520 So. Washington St.	
17. INFORMANT Alexandria, Virginia		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowning DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fell into 3' of water while cleaning stern of boat		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Fell into 3' of water while cleaning stern of boat		20c. TIME OF INJURY Month, Day, Year 4-23-62 Hour ? p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Boat		20f. (City or town) Rose Haven Yacht Club		20g. (County) Anne Arundel		20h. (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
ACTUAL SIGNATURE Peter W. Rieckert		M.D. PETER W. RIECKERT, M.D.		DATE SIGNED 4-23-62			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 4-23-62		22c. NAME OF CEMETERY OR CREMATORY Alexandria, Virginia		22d. LOCATION (City, town, or country) (State) Alexandria, Virginia	
23. FUNERAL DIRECTOR Wm J. Pickier & Sons		ADDRESS Baltimore, Md.		24a. REC'D BY REGISTRAR APR 24 '62		24b. REGISTRAR'S SIGNATURE Arthur L. Hume	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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FEB 11 1944

TO HOSPITAL 2 ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 5 to be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04083

CERTIFICATE OF DEATH

04079

1. PLACE OF DEATH a. COUNTY <u>Maryland</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - Annapolis</u>	
c. LENGTH OF STAY IN lb <u>1 mo. 21 da.</u>		d. STREET ADDRESS <u>Rt-4, Box-90</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Anne Arundel General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Margaret</u> Middle <u>BUTLER</u> Last <u>BUTLER</u>		4. DATE OF DEATH Month <u>April</u> Day <u>12</u> Year <u>1962</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 6, 1908</u>
9. AGE (In years last birthday) <u>53</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Morris Butler</u>		14. MOTHER'S MAIDEN NAME <u>Drene Henson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u> </u> ADDRESS <u>Maryland R. 4 Box 90 Annapolis Md.</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute cardiac failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive cardiovascular disease</u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u> </u>			
INTERVAL BETWEEN ONSET AND DEATH <u>5 weeks</u> <u>10 years</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Hour a.m. <u> </u> p.m. <u> </u> Month, Day, Year <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) (County) (State) <u> </u>
21. I certify that (I) <u>William Reese</u> attended the deceased from <u>Feb. 23, 1962</u> , to <u>Apr. 12, 1962</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>Apr. 12, 1962</u> , and that death occurred at <u> </u> M. from the causes and on the date stated above.			
22a. SIGNATURE <u>Aris T. Allen</u>		22b. DATE SIGNED <u>4/13/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Aris T. Allen, M.D.</u>		22d. ADDRESS <u>52 Cathedral St., Annapolis, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4-17-1962</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St. Margaret Mc</u>		23d. LOCATION (City, town or county) (State) <u> </u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese</u>		25a. REC'D BY REGISTRAR <u>APR 19 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur E. Kraus</u>		25c. REGISTRAR'S SIGNATURE <u> </u>	

01019

01019

1. Name of the person

1. Name of the person

2. Date of birth

2. Date of birth

3. Place of birth

3. Place of birth

4. Date of death

4. Date of death

5. Sex

5. Sex

6. Race

6. Race

7. Religion

7. Religion

8. Education

8. Education

9. Occupation

9. Occupation

10. Address

10. Address

11. Telephone

11. Telephone

12. Social Security Number

12. Social Security Number

13. Date of application

13. Date of application

14. Signature

14. Signature

15. Date of completion

15. Date of completion

16. Remarks

16. Remarks

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 is to be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04084

04080

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Washington, D.C.</u> b. COUNTY <u>✓</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u> <u>47X-3</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Children's Center</u>				d. STREET ADDRESS <u>318 15th Street, N.E.</u>			
3. NAME OF DECEASED (Type or print) <u>Alfred</u> First <u>Carbonaro</u> Middle Last				4. DATE OF DEATH Month <u>April</u> Day <u>21</u> Year <u>1962</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-23-21</u>	
9. AGE (In years last birthday) <u>41</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Imate</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph Carbonaro</u>				14. MOTHER'S MAIDEN NAME <u>Josephine</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>DTS Records</u>		17. INFORMANT <u>Laurel, Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aspiration of vomitus</u> <u>325.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Mental retardation - severe (Idiot) from birth</u> (c) <u>4/21/62</u> DUE TO (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pulmonary tuberculosis - inactive on therapy</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u> </u> a.m. <u> </u> p.m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>12/13</u> , 19 <u>29</u> to <u>Present</u> , 19 <u> </u> , that (I) (we) last saw the deceased alive on <u>4/20/62</u> , 19 <u> </u> , and that death occurred <u>4/20/62</u> p.m. from the causes and on the date stated above.							
22a. SIGNATURE <u>James E. Boyland</u>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>4/24/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>James E. Boyland, M.D.</u> <u>James E. Boyland</u>				22d. ADDRESS <u>Children's Center, Laurel, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4-25-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Children's Center</u>		23d. LOCATION (City, town or county) (State) <u>Laurel</u> <u>Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John Dewhirst</u>				25a. REC'D BY REGISTRAR <u>4-25-62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Krause</u>	

APR 26 '62

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STATE OF TEXAS

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FOR STATE
HEALTH DEPT. (M)

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04085

04081

1. PLACE OF DEATH a. COUNTY <u>Maryland</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Millersville</u> c. LENGTH OF STAY IN 1b <u>?</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Route 3, North Bound Lane.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>East Linthicum Heights</u> d. STREET ADDRESS <u>103 Juniper Circle</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Eileen Marjorie Clark</u> First Middle Last		4. DATE OF DEATH <u>April 12 1962</u> Month Day Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/20/26 20/26</u>
9. AGE (In years last birthday) <u>35</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u>		10. AGE (In years last birthday) <u>35</u> yrs. IF UNDER 24 HRS.: Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>New York N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jack Spencer</u>		14. MOTHER'S MAIDEN NAME <u>Florence XXXXX Ahearn</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give year or dates of service) <u>////////</u>		16. SOCIAL SECURITY NO. <u>212-20-0085</u>	
17. INFORMANT <u>Robert Fulton Clark (husband)</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Crushing injuries to head, chest and extremities</u> DUE TO (b) <u>936.5</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20. INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>No definite details</u>		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.) <u>Deceased was found on the side of the road.</u>	
20c. TIME OF INJURY Month, Day, Year Hour e.m. <u> </u> p.m. <u>4/12/62 19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Route 3, Millersville, A.A. Md.</u> 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> <u>Undetermined manner</u> <input checked="" type="checkbox"/>			
ACTUAL SIGNATURE <u>Rudiger Breiteneker</u>		DATE SIGNED <u>April 12, 1962</u>	
EXAMINER'S NAME (Type) <u>Rudiger Breiteneker, M.D.</u>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county) <u> </u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>16th April '62</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Most Holy Redeemer Cem.</u>	22d. LOCATION (City, town, or country) (State) <u>Baltimore, Maryland</u>
23. FUNERAL DIRECTOR <u>Richard V. Sigillo</u>		24a. REC'D BY REGISTRAR <u>APR 17 '62</u>	
24b. REGISTRAR'S SIGNATURE <u>Glenn Burnie, Md.</u>		24c. REGISTRAR'S SIGNATURE <u>William S. Thomas</u>	



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Scientific interest in head, neck and expression

X

Handwritten signature

July 12, 1905

Handwritten signature

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04086
CERTIFICATE OF DEATH
04082

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millersville c. LENGTH OF STAY in lb 1 week d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Knollwood Manor Nursing Home		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY A. A. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore Suburban d. STREET ADDRESS Knoll View Beach, Pasadena e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Elizabeth First Middle Last Clough		4. DATE OF DEATH April 23, 19 62 Month Day Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Dec. 19, 1867 Yrs. Months Days
9. AGE (In years last birthday) 94		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Baltimore, Md.	
11. BIRTHPLACE (County & State, or foreign country) U. S.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Conrad Kistner		14. MOTHER'S MAIDEN NAME Caroline Kistner	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Pasadena, Md.	
17. INFORMANT Mrs. Caroline W. Meyer, Knoll View Beach,		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) Disease (c) 3 mos PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. p.m. 8:30 PM		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Mar 62 to 4/23 , 19 62 , that (I) (we) last saw the deceased alive on 4/22 , 19 62 and that death occurred 8:30 PM from the causes and on the date stated above.			
22a. SIGNATURE Richard W. Peeler M.D.		22b. DATE SIGNED 4/23/62	
22c. PHYSICIAN'S NAME (Type) RICHARD W. PEELER		22d. ADDRESS ANNAPOLIS, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF April 26, 1962	
23c. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial Park		23d. LOCATION (City, town or county) (State) Anne Arundel Co., Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE George B. Gonce ADDRESS 4001 Ritchie Hwy.		25a. REC'D BY REGISTRAR APR 27 '62	
25b. REGISTRAR'S SIGNATURE Arthur L. Hines			

08082

08082

(M)

(I)

Handwritten notes and stamps, including "JAN 1962" and "RECEIVED".

Handwritten notes and stamps, including "RECEIVED" and "JAN 1962".

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 7/61

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
04087					04083						
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)						
a. COUNTY		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			a. STATE		b. COUNTY				
Anne Arundel		Crownsville			Maryland		Baltimore City				
		c. LENGTH OF STAY in 1b					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)				
		4 years 1 mo. 4 days					Baltimore				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					d. STREET ADDRESS						
Crownsville State Hospital					221 South Myrtle Avenue						
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH						
First Middle Last					Month Day Year						
Charles Coleman					4 11 19 62						
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)			
Male		Negro		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		1894		67 yrs.			
								IF UNDER 1 YEAR IF UNDER 24 HRS.			
								Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
Laborer					-----		Virginia		U.S.A.		
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME						
Drakon Coleman					Betty						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)					16. SOCIAL SECURITY NO.		17. INFORMANT Address				
Yes Unknown					Unknown		Hospital Records				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)											
334 X Uremia											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
(b) Dehydration and Senility											
(c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
CBS with General & Cerebral Arteriosclerosis - Myocardial Ischemia											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						

20c. TIME OF INJURY		Month, Day, Year		20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
Hour a.m. p.m.		----- 19		While at work <input type="checkbox"/> While not at work <input type="checkbox"/>		factory, street, office bldg., etc.)		-----			
21. I certify that (I) (this hospital) attended the deceased from 3/7 1958, to 4/11 1962, that (I) (we) last saw the deceased alive on 4/11 1962, and that death occurred at 11A.M. from the causes and on the date stated above.											
22a. SIGNATURE					M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 4/12/62		
22c. PHYSICIAN'S NAME (Type)					22d. ADDRESS						
Lionel McHenry Mapp, M. D.					Crownsville State Hospital, Maryland						
23a. BURIAL, CREMATION, or REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)					
Burial		4-16-62		Baltimore Natl Cem		Baltimore Md					
24. FUNERAL DIRECTOR'S SIGNATURE					ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Charles H. Cooper 512 (Annotating)							DATE APR 13 '62		Charles S. Thomas		

04083

04083

James M. Campbell

Greenwich, Conn.

Greenwich State Hospital

Greenwich

Wife of James Campbell

Greenwich

Greenwich, Conn.

Greenwich, Conn.

Greenwich

Greenwich, Conn.

One with General & State of Conn. & Hospital Records

Greenwich, Conn.

Greenwich, Conn.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04088

CERTIFICATE OF DEATH

04084

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 10		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis		d. STREET ADDRESS 131 Market Street	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Anne Arundel General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Ferdinand C DAMMEYER				4. DATE OF DEATH 4 19 19 62			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-12-81		9. AGE (In years last birthday) 81 yrs.	IF UNDER 1 YEAR Months 4 Days 19	IF UNDER 24 HRS. Hours 19 Min. 62
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber Ret. Barber			10b. KIND OF BUSINESS OR INDUSTRY Barber		11. BIRTHPLACE (County & State, or foreign country) Annapolis Md. U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME John Henry Dammeier			14. MOTHER'S MAIDEN NAME Elise Fahlbusch				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No			16. SOCIAL SECURITY NO. 1		17. INFORMANT LILLIE J. DAMMEYER Address Hospital files		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Renal insufficiency 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ?							INTERVAL BETWEEN ONSET AND DEATH 14 days
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4/15, 1962 to 4/19, 1962 , that (I) (we) last saw the deceased alive on 4/19, 1962 , and that death occurred at 7:55 P. M, from the causes and on the date stated above.							
22a. SIGNATURE Richard I. Hochman M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Richard I. Hochman, M.D.				22d. ADDRESS Franklin Street, Annapolis, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-23-1962		23c. NAME OF CEMETERY OR CREMATORY St Marys Cent		23d. LOCATION (City, town or county) (State) Annapolis Md	
24. FUNERAL DIRECTOR'S SIGNATURE John M. Teylor Sins				ADDRESS Annapolis Md		25a. REC'D BY REGISTRAR DATE APR 24 '62	
				25b. REGISTRAR'S SIGNATURE Arthur L. Kraus			

18010

CERTIFICATE OF DEATH

10022

[Faint, mostly illegible text from a death certificate form, including fields for name, date, and location.]

[Handwritten signature: "John W. ..."]

[Handwritten date: "4/19/22"]

[Handwritten text: "4/19/22"]

04089

CERTIFICATE OF DEATH

Reg. Dist. No.

04085

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort George G. Meade	c. LENGTH OF STAY IN 1b -	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort George G. Meade	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION KIM ROUGH ARMY HOSPITAL		d. STREET ADDRESS Qtrs # 7106-B	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First DAVIDSON Middle DAVIDSON Last DAVIDSON		4. DATE OF DEATH Month APRIL Day 1 Year 1962	
5. SEX Female	6. COLOR OR RACE Mongolian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 31 Mar 62
9. AGE (In years last birthday) yrs. 10		IF UNDER 1 YEAR Months 10 Days 23	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James E Davidson		14. MOTHER'S MAIDEN NAME Michiko Kikuchi	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) -		16. SOCIAL SECURITY NO. -	
17. INFORMANT Mother-Qtrs #7106B Ft Geo G. Meade, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 776 X IMMEDIATE CAUSE (a) Premature Birth - Neonatal death DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 10 hrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 31 Mar , 19 62 , to 1 Apr 62 , that I last saw the deceased alive on 1 Apr , 19 62 , and that death occurred at 4:15A M, from the causes and on the date stated above. ADDRESS (Street, City or town, state) Kimrough Army Hospital 1 Apr 62 DATE SIGNED ACTUAL SIGNATURE Stuart Bernstein M.D. Kimrough Army Hospital 1 Apr 62 PHYSICIAN'S NAME (Type) STUART BERNSTEIN, Capt., M.C.			
22a. BURIAL, CREMATION, REMAINS (Specify) 2 Apr 62		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY Kimrough Army Hospital Ft. Geo G. Meade, Maryland		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE William J. Steyer		24a. REC'D BY REGISTRAR APR 5 '62	
24b. REGISTRAR'S SIGNATURE Arthur L. Frank			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the medical director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2-039057

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04090

CERTIFICATE OF DEATH

Item 23a Film G312 5/2/62 iwk

04086

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Crownsville c. LENGTH OF STAY in 1b 7 years 10 mos. 23 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Crownsville State Hospital			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE Maryland b. COUNTY Baltimore City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 893 Boyd Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Norman			4. DATE OF DEATH Month 4 Day 26 Year 1962		
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH September 7, 1921		9. AGE (In years last birthday) 40 yrs.		10. IF UNDER 1 YEAR Months 4 Days 26	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		12. KIND OF BUSINESS OR INDUSTRY -----		13. BIRTHPLACE (County & State, or foreign country) Maryland	
14. FATHER'S NAME Unknown		15. MOTHER'S MAIDEN NAME Unknown		16. CITIZEN OF WHAT COUNTRY? U.S.A.	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		18. SOCIAL SECURITY NO. Unknown		19. INFORMANT Hospital Records Address	
20. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia 521X DUE TO Conditions, if any, which gave rise to immediate cause (b) Lung Abscess (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Brain Syndrome Associated with Central Nervous System Syphilis					
21. 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 026X					
22c. TIME OF INJURY Hour e.m. 19 p.m. 19		23d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		24e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----	
25d. (City or town) -----		26d. (County) -----		27d. (State) -----	
28. I certify that (I) (this hospital) attended the deceased from 6/3 to 4/26 , 19 62 , that (I) (we) last saw the deceased alive on 4/26 , 19 62 , and that death occurred at 10:15 AM, from the causes and on the date stated above.					
29. SIGNATURE Lionel McHenry Mapp, M. D.		30. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS Crownsville State Hospital, Maryland		31. DATE 4/26/62	
32. BURIAL, CREMATION, REMOVAL (Specify) Buried		33. DATE THEREOF 5-1-62		34. NAME OF CEMETERY OR CREMATORY MT. Calvary	
35. LOCATION (City, town or county) Bethesda Md.		36. (State) -----		37. REC'D BY REGISTRAR APR 30 '62	
38. REGISTRAR'S SIGNATURE Arthur S. Kraus		39. REGISTRAR'S SIGNATURE Arthur S. Kraus		40. REGISTRAR'S SIGNATURE Arthur S. Kraus	

01086

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George Washington

George Washington

George Washington

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie c. LENGTH OF STAY IN b few seconds d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Intersection of routes #2 & #3			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Same b. COUNTY Same c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Glen Burnie d. STREET ADDRESS 301 Furnace Branch Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Clyde Brice Didlake, Jr.			4. DATE OF DEATH Month April Day 3 Year 1962		
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH June 10, 1942		9. AGE (In years last birthday) 19 yrs.		IF UNDER 1 YEAR Months 19 Days 19	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bus Driver		10b. KIND OF BUSINESS OR INDUSTRY Co-owner of buses with father.		11. BIRTHPLACE (State or foreign country) Glen Burnie, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Clyde B. Didlake, Sr.		14. MOTHER'S MAIDEN NAME Irene Owens	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 218-36-8979		17. INFORMANT Parents	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Avulsion of brain from cranial cavity. DUE TO (b) Complete severance of 1/3 of upper part of skull. DUE TO (c) Crushed Chest & Compound Comminuted fracture/left arm and left leg, (also rt. a.) CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Numerous deep lacerations of body and extremities incl. (protrusion of guts).					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) His car was in a collision with a tractor and trailer truck.			
20c. TIME OF INJURY Month, Day, Year 9:17 p.m. 4/3 1962		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Routes #2 & #3	
20f. (City or town) Glen Burnie, A.A.Co., Md.		20g. (County) Glen Burnie, Md.			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
DATE SIGNED 4/3/62					
ACTUAL SIGNATURE Gustave H. Faubert, M.D.					
EXAMINER'S NAME (Type) Gustave H. Faubert, M.D.					
Address (Street, city, town, or county) Glen Burnie, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 7, 1962		22c. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial	
22d. LOCATION (City, town, or country) Glen Burnie, Md.		22e. (State) Md.			
23. FUNERAL DIRECTOR Hopping and Kirkley ADDRESS Glen Burnie, Md.					
24a. REC'D BY REGISTRAR APR 9 '62					
24b. REGISTRAR'S SIGNATURE Gustave H. Faubert					



Hopping and Kirkley, Glen Burnie, Md.
April 7, 62 Glen Haven Memorial Glen Burnie, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04092

04088

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Odenton</u> c. LENGTH OF STAY IN TB <u>4 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>#218 Rita Drive</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Odenton</u> d. STREET ADDRESS <u>#218 Rita Drive</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>GLEN M. EVANS</u>				4. DATE OF DEATH <u>April 23rd 1962</u>							
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>26th June 1899</u>		9. AGE (In years last birthday) <u>62</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> IF UNDER 24 HRS.: Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer (ret.)</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Civil Serv.</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Edinburg, Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Evans</u>				14. MOTHER'S MAIDEN NAME <u>Lucy Barton</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service) <u>Unknown</u>				16. SOCIAL SECURITY NO. <u>Unknown</u>				17. INFORMANT <u>Mrs. Mary Jones</u> Address <u>524 E. 30th st., Balto '18</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolus.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>433.1</u> DUE TO <u>Arterial Fibrillation due to</u> DUE TO <u>Cardiac Failure to S.P.U.D.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus - controlled -</u>								INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u> </u> p.m. <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>			
21. I certify that (I) (this hospital) attended the deceased from <u>June 1958</u> to <u>April 23, 1962</u> that (I) (we) last saw the deceased alive on <u>April 20, 1962</u> and that death occurred at <u>2 p.m.</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>Febois Grunberg</u>				22b. DATE <u>4/24/62</u>							
22c. PHYSICIAN'S NAME (Type) <u>Febois Grunberg</u>				22d. ADDRESS <u>609 Odenton Rd. Odenton</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>26th June '62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Meadowridge Mem. Park</u>		23d. LOCATION (City, town or county) <u>Howard County, Maryland</u> (State) <u> </u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Richard V. Singleton</u>				25a. REC'D BY REGISTRAR <u>APR 27 '62</u>				25b. REGISTRAR'S SIGNATURE <u>William S. Thayer</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4 should be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04093

04089

1. PLACE OF DEATH a. COUNTY AA MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY AA			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Glen Burnie				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Glen Burnie			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 963 Princeton Terrace				d. STREET ADDRESS 963 Princeton Terrace			
3. NAME OF DECEASED (Type or print) First LOUISE, Middle M. Last FLEURY				4. DATE OF DEATH Month 4 Day 27 Year 19 62			
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/13/79	
9. AGE (In years last birthday) 82		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? Same	
13. FATHER'S NAME Jos. Conway				14. MOTHER'S MAIDEN NAME Martha Weber			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. Family			
17. INFORMANT Family				Address Same			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio-sclerotic heart disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral sclerosis (c) Coronary heart disease				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 19 60 to April 20 19 62 that (I) (we) last saw the deceased alive on April 20 19 62 and that death occurred at 7:10 A.M. from the causes and on the date stated above.							
22a. SIGNATURE Samuel Rubin				22b. DATE SIGNED 4/27/62			
22c. PHYSICIAN'S NAME (Type) Samuel Rubin, M.D.				22d. ADDRESS 203 Patapsco Ave., Balto. 25, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/30/ 62		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Cem.		23d. LOCATION (City, town or county) (State) Glen Burnie, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE McCully Funeral Homes 130 E. Fort Ave.				25a. REC'D BY REGISTRAR APR 30 '62		25b. REGISTRAR'S SIGNATURE Arthur L. Kiana	

04082

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General Electric
Corporation
New York, N.Y.

April 20, 1944

805 74 42000 Ave., Baiton, T. N.

General Electric Corporation

General Electric Corporation, 100 N. 10th Ave.,
P.O. Box 100, St. Louis, Mo.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 to be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
04094											
04090											
1. PLACE OF DEATH a. COUNTY <u>MARYLAND</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>AA.</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis MD.</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Anne Arundel Gen</u>						d. STREET ADDRESS <u>14 Bloomsbury Square</u>					
3. NAME OF DECEASED (Type or print) <u>Horrey L. Foster</u>						4. DATE OF DEATH <u>4-5-1962</u>					
5. SEX <u>M</u>						6. COLOR OR RACE <u>W</u>					
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>						8. DATE OF BIRTH <u>March 28, 1899</u>					
9. AGE (In years last birthday) <u>63</u>						10. IF UNDER 1 YEAR Months <u>4</u> Days <u>5</u> Hours <u>19</u> Min. <u>62</u>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Steel</u>						10b. KIND OF BUSINESS OR INDUSTRY <u>Steel</u>					
11. BIRTHPLACE (County & State, or foreign country) <u>Cepollo Penn U.S.</u>						12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>					
13. FATHER'S NAME <u>Emmott Foster</u>						14. MOTHER'S MAIDEN NAME <u>Lillian Tompson</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)						16. SOCIAL SECURITY NO.					
17. INFORMANT <u>Robert R. Severna</u>						Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Brain Tumor</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Cancer of Lung</u> (c) <u>Cancer of Lung</u> DUE TO cause last. (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.											
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)											
20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from <u>1955</u> to <u>1962</u> 19....., that (I) (we) last saw the deceased alive on <u>April 4, 1962</u> and that death occurred at <u>1962</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>Robert R. Severna</u> M.D.											
22b. DATE SIGNED <u>4/5/62</u>											
22c. PHYSICIAN'S NAME (Type or print) <u>Robert R. Severna</u>											
22d. ADDRESS <u>Severna Park</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>											
23b. DATE THEREOF <u>Apr 9-1962</u>											
23c. NAME OF CEMETERY OR CREMATORY <u>Greenwood Cent</u>											
23d. LOCATION (City, town or county) (State) <u>Vandergrift Pa</u>											
24. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor Sons</u>											
25a. REC'D BY REGISTRAR <u>APR 9 '62</u>											
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>											

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 shall be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04095

CERTIFICATE OF DEATH

04092

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis c. LENGTH OF STAY IN lb 10 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis d. STREET ADDRESS P.O. Box 27 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Frank A. Grant		4. DATE OF DEATH April 19 19 62	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-30-08
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK		11. BIRTHPLACE (County & State, or foreign country) N.Y.	
13. FATHER'S NAME Frank A. Grant		14. MOTHER'S MAIDEN NAME Mahmud -	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes		16. SOCIAL SECURITY NO. 21-20-11	
17. INFORMANT Hospital files		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Vascular collapse - shock DUE TO (b) Hemorrhage Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. Carcinoma of stomach		INTERVAL BETWEEN ONSET AND DEATH few hours 6 days unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4-15 1962 to 4-19 1962 , that (I) (we) last saw the deceased alive on 4-19 1962 , and that death occurred at 3:30 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Barber C. Palmer Jr.		22b. DATE SIGNED 4-23-62	
22c. PHYSICIAN'S NAME (Type) Barber C. Palmer, Jr. M.D.		22d. ADDRESS 77 Franklin St. Annapolis, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-24-1962	
23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town or county) (State) Arlington Va	
24. FUNERAL DIRECTOR'S SIGNATURE John M. Saylor Sons		25a. REC'D BY REGISTRAR DATE APR 24 '62	
ADDRESS Annapolis Md.		25b. REGISTRAR'S SIGNATURE Arthur L. Harris	

01032

CERTIFICATE OF DEATH

01032

John Doe

John Doe

Residence

Residence

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Box 12

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04096

04093

1. PLACE OF DEATH a. COUNTY <i>a a</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>a a</i>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. LENGTH OF STAY IN 1b <i>X</i> <i>Arnold</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>A. C. General Hospit.</i>		d. STREET ADDRESS <i>Rt. 3 Box 224</i>	
3. NAME OF DECEASED (Type or print) <i>PHYLLIS ROGERS GREEN</i>		4. DATE OF DEATH Month <i>4</i> Day <i>15</i> Year <i>1962</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec 11th 1922</i>
9. AGE (In years last birthday) <i>39</i> yrs.		10. IF UNDER 1 YEAR Months <i>3</i> Days <i>3</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	
11. BIRTHPLACE (Country & State, or foreign country) <i>Oak Park Ill.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Howard R. Rogers</i>		14. MOTHER'S MAIDEN NAME <i>Marilla Harrington</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <i>-</i>	
17. INFORMANT <i>Marilla Harrington</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Subarachnoid hemorrhage</i> <i>330 X</i> DUE TO Conditions, if any, which gave rise to immediate cause (b) <i>Ruptured aneurysm Circle of Willis 15 hrs.</i> (a), stating the underlying cause last. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>649 X</i> <i>Intrauterine Pregnancy, 38 wks.</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>4/14, 1962</i> to <i>4/15, 1962</i> , that (I) (we) last saw the deceased alive on <i>4/15, 1962</i> , and that death occurred at <i>6:20 AM</i> , from the causes and on the date stated above.			
22a. SIGNATURE <i>Arthur M. Carithers Jr.</i> M.D.		22b. DATE SIGNED <i>4/15/62</i>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		23b. DATE THEREOF <i>Apr 17th 1962</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>St Lincoln Cemt</i>		23d. LOCATION (City, town or county) (State) <i>Prince Geo Co Md</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>John W. Taylor Sons</i>		25a. REC'D BY REGISTRAR DATE <i>APR 17 '62</i>	
25b. REGISTRAR'S SIGNATURE <i>Arthur J. Hume</i>			

6030

242

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04097

CERTIFICATE OF DEATH

04094

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gambrells</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gambrells</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>SAMUEL GREENLEAF</u>		4. DATE OF DEATH Month <u>4</u> Day <u>13</u> Year <u>1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cole</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-1-1910</u>
9. AGE (In years last birthday) <u>51</u> yrs.		10. IF UNDER 1 YEAR Months Days	
11. IF UNDER 24 HRS. Hours Min.		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry Greenleaf</u>		14. MOTHER'S MAIDEN NAME <u>Martha Thomas</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) (If yes give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Rosie Greenleaf Gambrells</u>	
17. INFORMANT Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO <u>Chronic pyelonephritis</u> DUE TO <u>Nephrocalcinosis</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>3/31</u> , 19 <u>62</u> to <u>4/12</u> , 19 <u>62</u> ; that (I) (we) last saw the deceased alive on <u>4/12</u> , 19 <u>62</u> , and that death occurred at <u>4/12</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Richard N. Peeler</u> M.D.		22b. DATE SIGNED <u>4/14/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>RICHARD N. PEELER</u>		22d. ADDRESS <u>Gambrells, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4-16-62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Wilsons Memorial</u>		23d. LOCATION (City, town or county) (State) <u>Gambrells Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>William Keese</u> ADDRESS <u>Arundel, Md.</u>		25a. REC'D BY REGISTRAR <u>APR 19 '62</u>	
		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>	

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CERTIFICATE OF DEATH

1. Name of deceased: *John Doe*
2. Sex: *Male*
3. Age: *45*
4. Date of death: *10/15/1945*
5. Place of death: *Home*
6. Cause of death: *Heart disease*
7. Signature of physician: *[Signature]*
8. Signature of registrar: *[Signature]*
9. Date of registration: *10/20/1945*
10. Place of registration: *City Hall*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 is to be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04099

CERTIFICATE OF DEATH

04096

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PASADENA</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PASADENA</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HICKORY POINT RD. - "TREE TOP FARM"</u>				d. STREET ADDRESS <u>HICKORY POINT - RT. 1</u>			
3. NAME OF DECEASED (Type or print) <u>GEORGE DAWSON GROOM</u>				4. DATE OF DEATH Month <u>APRIL</u> Day <u>28</u> Year <u>1962</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 28, 1908</u>	
9. AGE (In years last birthday) <u>53</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CONTRACTOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HEAVY CONSTRUCTION</u>		11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>GEORGE GROOM</u>			
14. MOTHER'S MAIDEN NAME <u>MAMIE -</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT <u>FAMILY RECORDS</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO (b) <u>Increased intracranial pressure</u> DUE TO (c) <u>Glioblastoma</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>6 mos.</u> <u>10 yrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (did not) attended the deceased from <u>Feb.</u> <u>1962</u> to <u>28 Apr.</u> <u>1962</u> , that (I) (was) last saw the deceased alive on <u>27 Apr.</u> <u>1962</u> , and that death occurred at <u>1:49</u> A.M. from the causes and on the date stated above.							
22a. SIGNATURE <u>E. Earl Hill</u>				22b. DATE SIGNED <u>28 Apr 62</u>		22c. PHYSICIAN'S NAME (Type) <u>E. Earl Hill</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				23b. DATE THEREOF <u>MAY 1, 1962</u>		23c. NAME OF CEMETERY OR CREMATORY <u>WOODLAWN CEMETERY</u>	
23d. LOCATION (City, town or county) (State) <u>WOODLAWN, BALTO. CO., MD.</u>				24. FUNERAL DIRECTOR'S SIGNATURE <u>John Burns' Sons, Towson, Md.</u>			
25a. REC'D BY REGISTRAR DATE <u>MAY 3 '62</u>				25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			



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24-5
20-3
10-1
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5/10/2020
 Increased intracranial pressure
 Pneumonia

Family Records

12

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. Page 4 must be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 10 Annapolis			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) (Dead on arrival) Anne Arundel General Hospital			d. STREET ADDRESS 88 College Creek Terrace		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Matilda			4. DATE OF DEATH HALL April 9 19 62		
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 4, 1876	9. AGE (In years last birthday) 86 yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) COOK		10b. KIND OF BUSINESS OR INDUSTRY *****		11. BIRTHPLACE (County & State, or foreign country) Maryland A.A.Co.	
13. FATHER'S NAME Jack Dennis			14. MOTHER'S MAIDEN NAME Unknown		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 218-32-4482		17. INFORMANT Phillip T. Hall-88 College Crk. Terrace	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) auto Coronary Occlusion 42000 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. } DUE TO arteriosclerosis Heart Disease (c)					INTERVAL BETWEEN ONSET AND DEATH 1 day
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)			
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (we) attended the deceased from 9-4061 19 April 8, 19 62 , that (I) (we) last saw the deceased alive on April 8, 19 62 , and that death occurred at 4:10 AM from the causes and on the date stated above.					
22a. SIGNATURE A. T. Allen		M.D. A. T. Allen, M.D.		22b. DATE SIGNED APR 17 1962	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS 62 Cathedral St., Annapolis, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Apr. 12-62	23c. NAME OF CEMETERY OR CREMATORY Mt. ZION		23d. LOCATION (City, town or county) (State) Lothian, Md.
24. FUNERAL DIRECTOR'S SIGNATURE C.E. Hicks III			ADDRESS Annapolis, Md.		
25a. REC'D BY REGISTRAR DATE APR 17 1962			25b. REGISTRAR'S SIGNATURE Arthur S. Harris		

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Jack Daniels

No

118-21-422

U.S. A.A.C.O.

U.S. A.A.C.O. 118-21-422

A. E. Allen, W.E.

118-21-422

U.S. A.A.C.O. 118-21-422

118-21-422

U.S. A.A.C.O.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04101

04098

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Anne Arundel</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rte 2 Box 611</u>		c. LENGTH OF STAY IN 1b <u>5 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park</u>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Severna Park</u>				d. STREET ADDRESS <u>Rte 2, Box 611</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Stephen</u> Middle <u>Woods</u> Last <u>Harrison</u>				4. DATE OF DEATH Month <u>4</u> Day <u>6</u> Year <u>1962</u>					
5. SEX <u>M.</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec 10, 1891</u>			
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Capt in Merchant Marine</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Telghmans</u>		11. BIRTHPLACE (State or foreign country) <u>MD. S.</u>			
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>									
13. FATHER'S NAME <u>Cleaver M. Harrison</u>				14. MOTHER'S MAIDEN NAME <u>Melissa Jane Harrison</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>212-18-7871</u>		17. INFORMANT Address <u> </u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO <u>Atherosclerotic C. V. Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>								INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)								20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>			
20f. (City or town) (County) (State) <u> </u>									
21. I certify that (I) (this hospital) attended the deceased from <u>1960</u> 19 <u> </u> to <u> </u> 19 <u> </u> , that (I) (we) lost saw the deceased alive on <u>1962</u> 19 <u> </u> , and that death occurred at <u>1 P.M.</u> from the causes and on the date stated above.									
22a. SIGNATURE <u>Robert A. Holm</u>				22b. DATE SIGNED <u>4-6-62</u>					
22c. PHYSICIAN'S NAME (Type) <u>Robert A. Holm</u>				22d. ADDRESS <u>Severna Park</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9 April 1962</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Meadowridge Mem. Park</u>		23d. LOCATION (City, town, or county) (State) <u>Elkridge, Howard Co.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping and Kirkley</u>				25a. REC'D BY REGISTRAR <u>Glenn Burnie Md.</u>		25b. REGISTRAR'S SIGNATURE <u> </u>			

101101

CERTIFICATE OF DEATH

(M)

NAME: [illegible]
AGE: [illegible]
SEX: [illegible]
DATE OF BIRTH: [illegible]
DATE OF DEATH: [illegible]
PLACE OF DEATH: [illegible]
CAUSE OF DEATH: [illegible]
SIGNATURE: [illegible]
DATE: [illegible]
PLACE: [illegible]

CERTIFICATE OF DEATH

Reg. Dist. No. 04039

04102

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS				c. LENGTH OF STAY IN 1b 18 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. NAVAL HOSPITAL				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS			
d. STREET ADDRESS 109 CHESAPEAKE AVE.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM FRANKLIN HARRISON Jr.				4. DATE OF DEATH Month Day Year APRIL 8 19 62			
5. SEX MALE		6. COLOR OR RACE CAUC		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/20/71	
9. AGE (In years last birthday) yrs. 90		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER RET				10b. KIND OF BUSINESS OR INDUSTRY FARMER		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME WILLIAM HENRY HARRISON (DEC)				14. MOTHER'S MAIDEN NAME MARY LIZA WARD (DEC)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or (if town) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. NONE			
17. INFORMANT WILLIAM F. HARRISON, RFD #2, BOX 19, GLEN BURNIE				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 ACUTE LEFT VENTRICULAR FAILURE DUE TO (b) ARTERIOSCLEROTIC HEART DISEASE. DUE TO (c) SEVERAL YEARS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DYNAMITON ② PNEUMONIA ② NEPHROSCLEROSIS							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from 21 FEB 1962 to 8 APR 1962 that I last saw the deceased alive on 8 APR 1962, and that death occurred at 9:25 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE E. C. KEENE LT MC USNR				ADDRESS (Street, city or town, state) USNH ANNAPOLIS, MARYLAND			
DATE SIGNED APR 12 62							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Apr. 11-1962		22c. NAME OF CEMETERY OR CREMATORY Dundsonville Cent		22d. LOCATION (City, town, or county) (State) Dundsonville Md	
23. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor Sons				ADDRESS Annapolis Md.			
24a. REC'D BY REGISTRAR DATE APR 12 '62				24b. REGISTRAR'S SIGNATURE C. L. H. HARRIS			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04103

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04100

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Odenton c. LENGTH OF STAY IN 1b 27 y. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) By the door of the washroom, which is built about 15 feet from the house.				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Same b. COUNTY Same c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Odenton d. STREET ADDRESS Odenton e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Mrs. Nada C. Heasley				4. DATE OF DEATH April 29th 19 62			
5. SEX M F		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/5/99	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife and piano teacher		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME M.A. Moon				14. MOTHER'S MAIDEN NAME Carolyn C. Clauss			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes give year or dates of service) 216-24-5002-A		17. INFORMANT Husband.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) DUE TO (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)						INTERVAL BETWEEN ONSET AND DEATH Sudden	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		2Db. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> . CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 5/1/62 DATE SIGNED							
ACTUAL SIGNATURE Gustave H. Faubert		M.D. Gustave H. Faubert, M.D.		Address (Street, city, town, or county)		24b. REC'D BY REGISTRAR MAY 4 '62	
22b. BURIAL, CREMATION, REMOVAL (Specify) Burial		22c. DATE THEREOF May 2, 1962		22d. NAME OF CEMETERY OR CREMATORY Epiphany Cemetery		22e. LOCATION (City, town, or county) (State) Odenton, Md.	
23. BURIAL DIRECTOR Hopping and Kirkley		ADDRESS Glen Burnie, Md.		24a. REGISTRAR'S SIGNATURE Arthur S. France		DATE MAY 4 '62	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

01100

00103

(M)

(I)

By the door of the window, it is built into the house.

house the end of the window.

216-4-1000

University of California

San Antonio, TX.

University of California

San Antonio, TX.

Hopkins and University, San Antonio, TX.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. Page 4 must be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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VR A15 (4)
ISM 7/61

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
04104					04101						
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)						
a. COUNTY ANNE ARUNDEL					a. STATE MARYLAND						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS					b. COUNTY ANNE ARUNDEL						
c. LENGTH OF STAY IN 1b ANNAPOLIS					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 5 PARKE LANE					d. STREET ADDRESS 5 PARKE LANE						
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print)			First Middle Last			4. DATE OF DEATH			Month Day Year		
RONALD (n)			HERLIHY			APRIL			21 19 62		
5. SEX MALE		6. COLOR OR RACE CAUC		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9 JAN 1962		9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR Months Days	
								3 12		Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE				10b. KIND OF BUSINESS OR INDUSTRY NONE				11. BIRTHPLACE (County & State, or foreign country) ANNE ARUNDEL, MARYLAND			
13. FATHER'S NAME JOHN W. HERLIHY				14. MOTHER'S MAIDEN NAME MARY L. CARR				12. CITIZEN OF WHAT COUNTRY? UNITED STATES			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) NO				16. SOCIAL SECURITY NO.				17. INFORMANT JOHN W. HERLIHY 5 PARKE LANE, ANNA, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Viral pneumonitis 492x DUE TO Conditions, if any, which gave rise to immediate cause (b) Virus - organism undetermined (a), stating the underlying cause last. DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH 24 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (this hospital) attended the deceased from Jan 19, 1962 to April 11, 1962, that (we) last saw the deceased alive on April 11, 1962, and that death occurred at 7:30 A.M. from the causes and on the date stated above.											
22a. SIGNATURE M.D. McCoy LT MC USNR					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22d. ADDRESS U.S. NAVAL HOSPITAL, ANNAPOLIS, MARYLAND					22b. DATE SIGNED April 23, 1962	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 4-25-1962		23c. NAME OF CEMETERY OR CREMATORY Annapolis Md			23d. LOCATION (City, town or county) HAVERHILL MASS.			
24. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor Sins					25a. REC'D BY REGISTRAR DATE APR 24 '62					25b. REGISTRAR'S SIGNATURE Arthur L. Hume	

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04100

NAME: JAMES

ADDRESS:

3 PARK LANE

BORN:

CHICAGO

WIFE

JOHN W. KELLY

NO

CERTIFICATE OF DEATH

04101

NAME: JAMES

ADDRESS:

3 PARK LANE

BORN:

CHICAGO

WIFE

3

MARY L. KELLY

JOHN W. KELLY, 3 PARK LANE, CHICAGO, ILL.

Very greenish
Virus - organism not found

James W. Kelly

April 11, 1918

April 11, 1918

U.S. Army Hospital, Annapolis, Maryland

W. D. Kelley

U.S. Army Hospital, Annapolis, Maryland

U.S. Army Hospital, Annapolis, Maryland

April 11, 1918

April 11, 1918

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04105

04102

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS 10</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>A. A. GENERAL HOSPITAL</u>				d. STREET ADDRESS <u>614 BURNSIDE ST.</u>			
3. NAME OF DECEASED (Type or print) <u>MARGARET VIRGINIA HOFFMAN</u>				4. DATE OF DEATH Month <u>APRIL</u> Day <u>19</u> Year <u>1962</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV. 24, 1910</u>	9. AGE (In years last birthday) <u>51</u> yrs.	IF UNDER 1 YEAR Months <u>5</u> Days <u>19</u>	IF UNDER 24 HRS. Hours <u>19</u> Min. <u>62</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>VICE PRES. & SEC. ARUNDEL BUS CO.</u>				11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN C. HOFFMAN</u>				14. MOTHER'S MAIDEN NAME <u>FLORENCE HARTGE</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>-</u>			
17. INFORMANT <u>C. GILBERT HOFFMAN</u>				Address <u>ANNAPOLIS MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>175.0</u> IMMEDIATE CAUSE (a) <u>Generalized Circumstances</u> DUE TO (b) <u>Primary site - ovary, left.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. <u>19</u> p.m.	Month, Day, Year <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that (I) (this hospital) attended the deceased from <u>April 30, 1962</u> to <u>April 19, 1962</u> , that (I) (we) last saw the deceased alive on <u>April 19, 1962</u> and that death occurred at <u>7 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>E. Linhardt</u>				M.D.	ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>E. Linhardt</u>				22d. ADDRESS <u>Annapolis, Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>APR. 21, 1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>QUAKER BURIAL GARD. ANNE ARUNDEL CO. MD.</u>		23d. LOCATION (City, town or county) <u>ANNAPOLIS, MD.</u>		(State)	
24. FUNERAL DIRECTOR'S SIGNATURE <u>JOHN M. TAYLOR SONS</u>				25a. REC'D BY REGISTRAR <u>APR 24 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01102

01102

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Handwritten notes in the lower section, including "01102" and "01102".

Handwritten notes in the lower section, including "01102" and "01102".

Handwritten notes at the bottom of the page, including "01102" and "01102".

TO HOSPITAL, ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04106

CERTIFICATE OF DEATH

04103

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 10		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		d. STREET ADDRESS 107 Annapolis St.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital				a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Sue		First E. Middle HURLEY Last		4. DATE OF DEATH April 16 19 62		Day Month Year	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 18, 1888	
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Domestic		11. BIRTHPLACE (County & State, or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME Edward Riley Somers				14. MOTHER'S MAIDEN NAME Angeline Milligan			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no				16. SOCIAL SECURITY NO. Miss Donald Zindorf			
17. INFORMATION 2							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS DUE TO Conditions, if any, which gave rise to immediate cause (b) CEREBRAL ARTERIOSCLEROSIS DUE TO (e), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) DIABETES MELLITUS; RENAL CALCINOSIS LEFT				INTERVAL BETWEEN ONSET AND DEATH 16 Hours unknown			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour e.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (X) deceased attended the deceased from Apr. 2, 1962 to Apr. 16, 1962 , that (I) (X) last saw the deceased alive on Apr. 16, 1962 , and that death occurred at 7:10 PM from the causes and on the date stated above.							
22a. SIGNATURE Edward S. Beck				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 4/17/62	
22c. PHYSICIAN'S NAME (Type) Edward S. Beck, M.D.				22d. ADDRESS 71 Franklin St., Annapolis, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF April 19, 1962		23c. NAME OF CEMETERY OR CREMATORY St. Anne's Cem.		23d. LOCATION (City, town or county) (State) Annapolis Md.	
24. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor Sons				ADDRESS Annapolis Md.		25a. REC'D BY REGISTRAR APR 23 '62	
				25b. REGISTRAR'S SIGNATURE John S. Hines			

64103

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04107

04104

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Woodland Beach</u>		c. LENGTH OF STAY IN 1b <u>X</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Woodland Beach</u>		d. STREET ADDRESS <u>3602 Shadyside Drive</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>3602 Shadyside Drive</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Harvey Pomeroy Imlay</u>				4. DATE OF DEATH Day <u>19</u> Month <u>April</u> Year <u>1962</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept 13 1984</u>	
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Watchman</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>Melvin Pomeroy Imlay</u>	
14. MOTHER'S MAIDEN NAME <u>Margaret Jane Money</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u> </u> (If yes give war or dates of service) <u> </u>		16. SOCIAL SECURITY NO. <u>578 01 6536</u>		17. INFORMANT <u>Marie P. Imlay</u> Address <u>Woodland Beach</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>posterior myocardial infarct</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>cardiovascular disease</u> (a), stating the underlying cause last. } DUE TO <u>gen. arteriosclerosis</u> (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>insignificant</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>insignificant</u>							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>5:15</u> p.m. <u>4:45</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>3-1</u> , 19 <u>62</u> to <u>4-13</u> , 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>4-13</u> , 19 <u>62</u> , and that death occurred at <u> </u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Edith Rodler</u> M.D.				22b. DATE SIGNED <u>4-13-62</u>			
22c. PHYSICIAN'S NAME (Type) <u>45 Franklin St Annapolis Md</u>				22d. ADDRESS <u>Edith Rodler</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/23/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Washington, D. C.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph F. Birch's Sons</u>				25a. REC'D BY REGISTRAR <u>APR 23 '62</u>			
ADDRESS <u>Washington, D. C.</u>				25b. REGISTRAR'S SIGNATURE <u>Edith Rodler</u>			

01101

01101



[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "Faint", "Faint", "Faint" are visible.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville c. LENGTH OF STAY IN 1b 5 mos. 29 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Crownsville State Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 1428 Madison Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Raymond B Johnson		4. DATE OF DEATH Month Day Year 4 23 19 62	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 21, 1912
9. AGE (In years last birthday) yrs. 50		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Elevator Operator		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Johnson		14. MOTHER'S MAIDEN NAME Ella Columbia	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war and dates of service) No		16. SOCIAL SECURITY NO. 23-3-16-4469	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cavitary Tuberculosis of lungs DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): Paranoid Reaction			
INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----	
20c. TIME OF INJURY Month, Day, Year Hour a.m. ----- p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State) -----	
21. I certify that (I) (this hospital) attended the deceased from 10/24 , 19 61 , to 4/23 , 19 62 , that (I) (wa) last saw the deceased alive on 4/23 , 19 62 , and that death occurred at 7:50 P. M., from the causes and on the date stated above.			
22a. SIGNATURE L. Benedict, M. D.		22b. DATE 4/24/62	
22c. PHYSICIAN'S NAME (Type) L. Benedict, M. D.		22d. ADDRESS Crownsville State Hospital, Maryland	
23a. BURIAL, CREMATION, 23b. DATE THEREOF Buried 4/27/62		23c. NAME OF CEMETERY OR CREMATORY Richmond Va.	
23d. LOCATION (City, town or county) (State) Richmond Va.		24. FUNERAL DIRECTOR'S SIGNATURE Mrs. Kate R. Williams	
ADDRESS 3229 N. Schuyler		REC'D BY REGISTRAR APR 27 '62	
25b. REGISTRAR'S SIGNATURE Arthur S. Hanks			

04102

CERTIFICATE OF DEATH

10102



State of Virginia
County of Albemarle
I, the undersigned, Clerk of the Circuit Court of the County of Albemarle, do hereby certify that the within and foregoing is a true and correct copy of the original of the same as the same appears from the records of the said Court.
Witness my hand and the seal of the said Court at the City of Charlottesville, this 10th day of January, 1912.
Clerk of the Circuit Court of the County of Albemarle
[Signature]
[Seal]

VR A15 (4)
1SM 7/61

VR A15 (4)
1SM 7/61

04106

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		c. LENGTH OF STAY IN 1b <u>6 wks</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Plaza Manor Nursing Home</u>		d. STREET ADDRESS <u>19, Shipwright Street</u>	
3. NAME OF DECEASED (Type or print) First <u>Harriett</u> Middle <u>A</u> Last <u>JONES</u>		4. DATE OF DEATH Month <u>April</u> Day <u>5</u> Year <u>1962</u>	
5. SEX <u>F</u>		6. COLOR OR RACE <u>N.</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10/1/1883</u>	
9. AGE (In years, months, and days) <u>78</u> yrs.		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>8</u>	
11. IF UNDER 24 HRS. Hours <u>7</u> Min. <u>15</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Telbert Co. Md.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Telbert Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Nace JONES</u>		14. MOTHER'S MAIDEN NAME <u>Francis GARLAND</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mrs W. Clayton Carr</u>		Address <u>Annapolis Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Dehydration and Inanition</u> DUE TO (b) <u>Diarrhea.</u> DUE TO (c) <u>Malnutrition</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE. CONDITION GIVEN IN PART I (a) <u>Senility</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> e.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>2/21/1962</u> to <u>4/5/1962</u> , that (I) (we) last saw the deceased alive on <u>4/3/1962</u> , and that death occurred at <u>4:55 P.M.</u> from the causes and on the date stated above.		22a. SIGNATURE <u>Ernest M. Henry M.D.</u>	
22b. DATE SIGNED <u>4/5/62</u>		22c. PHYSICIAN'S NAME (Type) <u>Ernest M. Henry M.D.</u>	
22d. ADDRESS <u>2020 E. Street, Annapolis Md</u>		22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4-9-62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St. Anne's Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Annapolis Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor</u>		25a. REC'D BY REGISTRAR <u>Arthur S. Kline</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>		25c. DATE <u>APR 9 '62</u>	

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00108

00108

DECLARATION OF DEATH

State of New York
County of New York
I, the undersigned, Clerk of the County of New York, do hereby certify that the within and foregoing is a true and correct copy of the original as the same appears from the records of the County of New York.
In testimony whereof, I have hereunto set my hand and the seal of said County, at New York, this 1st day of January, 1908.
Clerk of the County of New York
By _____
Deputy Clerk

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville c. LENGTH OF STAY in 1b 22 years 5 mos. 27 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Crownsville State Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland f. COUNTY Baltimore City g. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore h. STREET ADDRESS 26 N. Eden Street i. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last #06582 William Jones		4. DATE OF DEATH Month Day Year 4 27 19 62	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1890
9. AGE (In years last birthday) 71 yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY -----	11. BIRTHPLACE (County & State, or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John Jones	
14. MOTHER'S MAIDEN NAME Martha		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Yes Unknown	
16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Hospital Records	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) Pulmonary Hemorrhage, Cause Unknown 783.1 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) -----		INTERVAL BETWEEN ONSET AND DEATH 783.1	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 10/30 5:20 PM to 4/27 1962		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State) -----	
21. I certify that (I) (this hospital) attended the deceased from 10/30 5:20 PM to 4/27 1962 , that (I) (we) last saw the deceased alive on 4/27 1962 , and that death occurred at ----- from the causes and on the date stated above.			
22a. SIGNATURE Lionel McHenry Mapp M.D.		22b. DATE 4/27/62	
22c. PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M. D.		22d. ADDRESS Crownsville State Hospital, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 5-2-62	
23c. NAME OF CEMETERY OR CREMATORY St. Mary's		23d. LOCATION (City, town or county) (State) Balto. Md.	
24. FUNERAL DIRECTOR'S SIGNATURE William Reese		25a. REC'D BY REGISTRAR DATE MAY 4 '62	
25b. REGISTRAR'S SIGNATURE Arthur S. Hume			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 shall be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

041108

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Crownsville c. LENGTH OF STAY in 1b 1 year 7 mos. 23 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Crownsville State Hospital		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE Maryland b. COUNTY Wicomico c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury d. STREET ADDRESS 607 Delaware Street e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) #23578 Willie		4. DATE OF DEATH Month 4 Day 29 Year 1962	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 21, 1882
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY -----	9. AGE (In years last birthday) 79 yrs.
13. FATHER'S NAME Jessie Jones		11. BIRTHPLACE (County & State, or foreign country) Virginia	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
16. SOCIAL SECURITY NO. 222-18-0814		14. MOTHER'S MAIDEN NAME Amy	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 491X IMMEDIATE CAUSE (a) Bronchopneumonia Hypostatic DUE TO Conditions, if any, which gave rise to immediate cause (b) (e), stating the underlying cause last. } DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Old Cerebrovascular Accident			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----	
20c. TIME OF INJURY Month, Day, Year Hour e.m. ----- 19 p.m. -----		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State) -----	
21. I certify that (I) (this hospital) attended the deceased from 4/17 10:25 to 4/29 , 19 62 , that (I) (we) last saw the deceased alive on 4/29 , 19 62 , and that death occurred at P.M. , from the causes and on the date stated above.			
22a. SIGNATURE Lionel McHenry Mapp, M. D.		22b. DATE 4/30/62	
22c. PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M. D.		22d. ADDRESS Crownsville State Hospital, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 5-2-62	
23c. NAME OF CEMETERY OR CREMATORY Wt. of Md.		23d. LOCATION (City, town or county) (State) Balto. Md.	
24. FUNERAL DIRECTOR'S SIGNATURE William Reese, Jr. - Annapolis, Md.		25a. REC'D BY REGISTRAR MAY 4 '62	
25b. REGISTRAR'S SIGNATURE Arthur S. Thomas			

04108

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7 Nov. 23 date

10 Nov. 23 date

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. **04109**

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL-PASADENA, MD</u> c. LENGTH OF STAY IN 1b <u>2 YEARS</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>219 GLEN ROAD</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL PASADENA</u> X d. STREET ADDRESS <u>219 GLEN ROAD</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last <u>HERBERT L KANE, Sr.</u>				4. DATE OF DEATH Month Day Year <u>APRIL 27 1962</u>					
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JUNE 22, 1885</u>		9. AGE (In years last birthday) <u>76</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MACHINIST</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>STEEL</u>		11. BIRTHPLACE (State or foreign country) <u>BALTO., MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Kane</u>				14. MOTHER'S MAIDEN NAME <u>ANNA. HIGGISON</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>217-01-8294</u>		17. INFORMANT <u>GORDON KANE</u>		Address <u>SAME</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTEROSCLEROTIC CARDIO VASCULAR DISEASE</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>4 2 2 1</u> DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH <u>4 YEARS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>HEMIPLEGIA (RIGHT)</u>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>OCT 1961</u> , to <u>APR. 27, 1962</u> , that I last saw the deceased alive on <u>4/20, 1962</u> , and that death occurred at <u>3:00 A.M.</u> , from the causes and on the date stated above.									
ACTUAL SIGNATURE <u>J. Brady Smith</u> M.D.				ADDRESS (Street, city or town, state) <u>8471 Ft. Smallwood Road</u>				DATE SIGNED <u>4/27/62</u>	
PHYSICIAN'S NAME (Type) <u>H. BRADY SMITH</u>				<u>PASADENA, MD.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/30/62</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard H. Hubbard, 4107 Wilkens Ave. #29</u>						24a. REC'D BY REGISTRAR DATE <u>APR 20 '62</u>		24b. REGISTRAR'S SIGNATURE <u>Virgil S. Thomas</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 Film G312 5/7/62 iwk

CERTIFICATE OF DEATH

04113

04110

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>West Virginia</u> 6. COUNTY <u>Anne Arundel</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort George Meade, Md</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Belle</u> <u>West Virginia</u> <u>85X.3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kimbrough Army Hospital FGGM, MD</u>		d. STREET ADDRESS <u>Belle</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>A</u> Last <u>Keeney</u>		4. DATE OF DEATH Month <u>Apr</u> Day <u>28</u> Year <u>1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cau</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 24, 1938</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Army</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Army</u>	
11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Winchester Keeney</u>		14. MOTHER'S MAIDEN NAME <u>Hazel</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>8/23/61-7/62</u>		16. SOCIAL SECURITY NO. <u>unknown</u>	
17. INFORMANT <u>Clinical Record Kimbrough Army Hospital</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sever Internal Injuries</u> DUE TO <u>823X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Sever trauma to pelvis and unary bladder</u> DUE TO (c) <u>Auto accident</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 1/2 Hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Pt. was driving auto and hit embankment</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>0300</u> <u>April 28</u> <u>1962</u>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Street</u>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>0335 Hrs 28 Apr 62</u> to <u>0650 28 Apr, 1962</u> , that I last saw the deceased alive on <u>28 Apr</u> , 19 <u>62</u> , and that death occurred at <u>0650</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Eugene F. Bonacci</u> M.D.		ADDRESS (Street, city or town, state) <u>KIMBROUGH ARMY HOSPITAL</u> DATE SIGNED <u>28 April 1962</u>	
PHYSICIAN'S NAME (Type) <u>Eugene F. Bonacci MD.</u>		FORT GEORGE G. MEADE, MARYLAND	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>3/30/62</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Fulder & Francis Funeral</u>		22d. LOCATION (City, town, or county) (State) <u>Belle - West Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Carl W. Gumbert</u> ADDRESS <u>6306 - Belair Rd, Baltimore 6, Md</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 3 '62</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kenna</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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SM 9/60

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
041114 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 041111

1. PLACE OF DEATH a. COUNTY Anne Arundel		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena		c. LENGTH OF STAY IN 1b 3 years		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Same		b. COUNTY Same		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Same		d. STREET ADDRESS Same		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Merrill W. Kellum Sr.		4. DATE OF DEATH April 22nd.		5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/7/03		9. AGE (In years last birthday) 58		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>		11. IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Weems Va.		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Joseph Kellum		14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-03-7482		17. INFORMANT Mrs. Dolores Kellum (wife)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Sudden		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		ACTUAL SIGNATURE Gustave H. Faubert		M.D. Gustave H. Faubert, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 4/22/62		Glen Burnie, Md.		Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4/25/62		22c. NAME OF CEMETERY OR CREMATORY ST. MARY'S HAMPDEN		22d. LOCATION (City, town, or country) (State) BALTO. MD.		23. FUNERAL DIRECTOR Paul E. Chenoweth		ADDRESS 3617 Chestnut Ave		24a. REC'D BY REGISTRAR APR 25 '62		24b. REGISTRAR'S SIGNATURE Arthur L. Hume		DATE			

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TO HOSPITAL, ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04115

04112

1. PLACE OF DEATH a. COUNTY <i>aa</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>Ma</i> b. COUNTY <i>aa</i>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Davidsonville</i>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Davidsonville</i>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Davidsonville Rd.</i>				d. STREET ADDRESS <i>R.F.D.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Lowell Modrall Kirk</i>				4. DATE OF DEATH Month <i>April</i> Day <i>13</i> Year <i>1962</i>			
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Oct 4 1905</i>	
9. AGE (in years last birthday) <i>56</i> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Executive Steele Co</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Dalhart Texas</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>William E. Kirk</i>				14. MOTHER'S MAIDEN NAME <i>Mellie Horn</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. <i>-</i>		17. INFORMANT Address <i>Louise Lounshend Kirk</i> (2)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Metastasis</i> <i>163X</i> DUE TO Conditions, if any, which gave rise to immediate cause (b) <i>Cancer of lung</i> (c) DUE TO (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e).						INTERVAL BETWEEN ONSET AND DEATH <i>7.00 am</i> <i>?</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>4-8-62</i> to <i>4-13-62</i> that (I) (we) last saw the deceased alive on <i>4-9-1962</i> and that death occurred at <i>2 PM</i> from the causes and on the date stated above.							
22a. SIGNATURE <i>Frank M. Shipley</i> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <i>FRANK M. SHIPLEY</i>				22d. ADDRESS <i>Annapolis, Md</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>4-16-1962</i>		23c. NAME OF CEMETERY OR CREMATORY <i>All Hallows Cem</i>		23d. LOCATION (City, town or county) (State) <i>Davidsonville Md</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor</i>				ADDRESS <i>Smo Annapolis, Md</i>		25a. REC'D BY REGISTRAR DATE <i>APR 17 '62</i>	
				25b. REGISTRAR'S SIGNATURE <i>Arthur S. Hines</i>			

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Handwritten notes, mostly illegible due to fading and bleed-through. Some legible fragments include:
"The following is a list of the names of the persons who have been named in the report of the committee on the subject of the proposed amendment to the constitution of the State of New York."
"The names of the persons named in the report are as follows: ..."

Handwritten notes at the bottom of the page, including:
"The following is a list of the names of the persons who have been named in the report of the committee on the subject of the proposed amendment to the constitution of the State of New York."
"The names of the persons named in the report are as follows: ..."

TO HOSPITAL 2. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

Item 9 Film G312 5/1/62 mh

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>AA. Co</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>DEALE</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>DEALE</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		d. STREET ADDRESS <u>Box 80, Orange Beach Rd</u>	
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>Knopp Jr</u> Last <u>Knopp Jr</u>		4. DATE OF DEATH Month <u>4</u> Day <u>17</u> Year <u>1962</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 14 - 1870</u> 19. AGE (In years last birthday) <u>91</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Builder</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) <u>Maryland, DEALE</u>
13. FATHER'S NAME <u>Joseph Knopp SR</u>		14. MOTHER'S MAIDEN NAME <u>MARIA Miller</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Mrs. Eva Burgess Deale, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Malignant melanoma of skin with multiple metastases</u> DUE TO (b) <u>Carcinoma of skin with multiple metastases</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Arteriosclerosis, generalized</u>			INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerosis, generalized</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>4-16</u> to <u>4-17</u> , 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>4-16</u> , 19 <u>62</u> , and that death occurred at <u>4:46</u> P.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>Chas. H. Kim</u> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>TAI Hoang Kim</u>		22d. ADDRESS <u>Shady side Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>April 17, 1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rogers Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Deale, Md</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>TA Hardesty + Son</u>		25a. REC'D BY REGISTRAR <u>APR 23 '62</u>	
ADDRESS <u>Galesville Md</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Huns</u>	

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4
may be retained in hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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041117
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

041114

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brooklyn 25 c. LENGTH OF STAY IN 1b Over 7 y. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5615 Bellegrove Rd.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Same b. COUNTY Same c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Same d. STREET ADDRESS Same e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Otto Koch Sr.				4. DATE OF DEATH Month April Day 25th Year 19 62			
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/8/82	
9. AGE (In years last birthday) 79 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired carpenter				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) Europe				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 215-10-7058		17. INFORMANT Mr. Francis Koch (son)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Deceased was admitted To Md. General Hospital on 4/2/62 (b) and treated by Dr. Stewart for Congestive Heart Failure and DUE TO Pulmonary Edema. Was discharged on 4/17/62 and returned to his (c) family physician Dr. Ball. As the latter is away and I am taken PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) care of his patients during his absence. When I was called last night				INTERVAL BETWEEN ONSET AND DEATH Sudden			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Mr. Otto Koch was D.O.A.			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from None 19 None to None 19 None , that (I) (we) lost saw the deceased alive on 19 , and that death occurred at M , from the causes and on the date stated above.							
22a. SIGNATURE Gustave H. Faubert, M.D.				22b. DATE 4/26/62		22c. PHYSICIAN'S NAME (Type) Gustave H. Faubert, M.D.	
22d. ADDRESS Glen Burnie, Md.				22e. DATE 4/26/62			
23a. BURIAL, CREMATION, REMOVAL (Specify) 4-30-62		23b. DATE THEREOF 4-30-62		23c. NAME OF CEMETERY OR CREMATORY Holy Cross		23d. LOCATION (City, town or county) (State) Deer	
24. FUNERAL DIRECTOR'S SIGNATURE McKee - 130 E Fort Ave.				25a. REGISTERED BY REGISTRAR APR 30 62		25b. REGISTRAR'S SIGNATURE Conrad J. Hume	

04113

CERTIFICATE OF DEATH

04114



RECEIVED
FEB 11 1964
U.S. DEPT. OF HEALTH
DIVISION OF VITAL STATISTICS

278

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

041119

CERTIFICATE OF DEATH

041116

Item 7 Film 0311 1/26/62 mb

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel.</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland.</u> b. COUNTY <u>Anne Arundel.</u>		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie.</u>			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		
c. LENGTH OF STAY IN Ib <u>1 Year</u>			d. STREET ADDRESS <u>Rt II Box 462</u>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Plaza Manor Nursing Home</u>			e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Henry</u> Last <u>Little</u>			4. DATE OF DEATH Month <u>April</u> Day <u>15</u> Year <u>1962</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>N.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 20th 1875</u>	9. AGE (In years last birthday) <u>86</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer - Gen. Utilities</u>			11. BIRTHPLACE (County, State, or foreign country) <u>Maryland A.A. Co. U.S.A.</u>		
13. FATHER'S NAME <u>James Little</u>			14. MOTHER'S MAIDEN NAME <u>Unknown.</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>217-30-4512A</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarct.</u> <u>420.</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardiovascular Disease.</u> DUE TO (c) <u>Generalized and Cerebral Arteriosclerosis.</u>			INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>February 19th 1962</u> to <u>April 15th 1962</u> , that (I) (we) last saw the deceased alive on <u>April 15th 1962</u> , and that death occurred at <u>10:00 AM</u> , from the causes and on the date stated above.					
22a. SIGNATURE <u>Lionel McHenry Mapp</u>			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type) <u>Lionel McHenry Mapp</u>			22d. ADDRESS <u>20 Dean Street, Annapolis Md.</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)
<u>BURIAL</u>		<u>Apr. 18-62</u>	<u>BROADNECK</u>		<u>A.A. Co. MARYLAND</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>C. E. Hicks</u>			25a. REC'D BY REGISTRAR DATE <u>APR 18 '62</u>		
ADDRESS <u>ANNAPOLIS - Md.</u>			25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>		

01116

01116

Handwritten notes, possibly a list or index, with various entries and markings. Includes phrases like "No. 1", "No. 2", "No. 3", "No. 4", "No. 5", "No. 6", "No. 7", "No. 8", "No. 9", "No. 10", "No. 11", "No. 12", "No. 13", "No. 14", "No. 15", "No. 16", "No. 17", "No. 18", "No. 19", "No. 20", "No. 21", "No. 22", "No. 23", "No. 24", "No. 25", "No. 26", "No. 27", "No. 28", "No. 29", "No. 30", "No. 31", "No. 32", "No. 33", "No. 34", "No. 35", "No. 36", "No. 37", "No. 38", "No. 39", "No. 40", "No. 41", "No. 42", "No. 43", "No. 44", "No. 45", "No. 46", "No. 47", "No. 48", "No. 49", "No. 50", "No. 51", "No. 52", "No. 53", "No. 54", "No. 55", "No. 56", "No. 57", "No. 58", "No. 59", "No. 60", "No. 61", "No. 62", "No. 63", "No. 64", "No. 65", "No. 66", "No. 67", "No. 68", "No. 69", "No. 70", "No. 71", "No. 72", "No. 73", "No. 74", "No. 75", "No. 76", "No. 77", "No. 78", "No. 79", "No. 80", "No. 81", "No. 82", "No. 83", "No. 84", "No. 85", "No. 86", "No. 87", "No. 88", "No. 89", "No. 90", "No. 91", "No. 92", "No. 93", "No. 94", "No. 95", "No. 96", "No. 97", "No. 98", "No. 99", "No. 100".

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 2 to be retained by the hospital or attending physician. Page 2 of 2 to be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04120

CERTIFICATE OF DEATH

04117

1. PLACE OF DEATH e. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) e. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Anne Arundel General Hospital				d. STREET ADDRESS 5 St. Mary's St.			
3. NAME OF DECEASED (Type or print) Bernard J. MARTIN				4. DATE OF DEATH Month April Day 29 Year 1962			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 20, 1916	
9. AGE (In years last birthday) 51 yrs.		IF UNDER 1 YEAR Months 51 Days 51		IF UNDER 24 HRS. Hours 51 Min. 51			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret.				10b. KIND OF BUSINESS OR INDUSTRY Elect. US GOV.		11. BIRTHPLACE (County & State, or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME Charles B. Martin				14. MOTHER'S MAIDEN NAME Gertrude Davis			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no				16. SOCIAL SECURITY NO. 216 18 5322			
17. INFORMANT Mrs Violet S. Martin- Wife- Same as # 2				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) U REMIA 177X DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) PYELOMEDPHRITIS DUE TO (c) CARCINOMA PROSTATE, METASTATIC				INTERVAL BETWEEN ONSET AND DEATH 5 DAYS 21 DAYS 2 mos.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) deceased attended the deceased from Apr. 4, 1962 , to Apr. 29, 1962 , that (I) last saw the deceased alive on Apr. 29, 1962 , and that death occurred at 10:35 AM , from the causes and on the date stated above.							
22a. SIGNATURE Edward S. Beck M.D.				22b. DATE SIGNED 4/30/62			
22c. PHYSICIAN'S NAME (Type) Edward S. Beck, M.D.				22d. ADDRESS 71 Franklin St., Annapolis, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 2, 1962		23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		23d. LOCATION (City, town or county) (State) Annapolis, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home				ADDRESS Annapolis, Md.		25a. REC'D BY REGISTRAR DATE	
				25b. REGISTRAR'S SIGNATURE Arthur S. Hance			

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04117

04118

James A. Smith

James A. Smith

James A. Smith

James A. Smith

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04121

Item 9 Film G312 5/1/62 mh

CERTIFICATE OF DEATH

04118

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince Frederick	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN IB 9 days.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Crownsville State Hospital		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Prince Frederick	
3. NAME OF DECEASED (Type or print) First Maurice Middle Mason Last Mason		4. DATE OF DEATH Month April Day 21 Year 1962	
5. SEX M	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/23/1894
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tobacco Stripper		10b. BUSINESS OR INDUSTRY Farm Hand	9. AGE (In years last birthday) 67 yrs.
11. BIRTHPLACE (County & State, or foreign country) Prince Frederick		12. CITIZEN OF WHAT COUNTRY? U. S. A	
13. FATHER'S NAME Hezitia P. Mason		14. MOTHER'S MAIDEN NAME Unknown Lillian Jefferson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. —	
17. INFORMANT Medical Record		Address —	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO Arteriosclerotic Heart Disease (b) General Arteriosclerosis (c) General Arteriosclerosis Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) —			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 4/12/1962 to 4/21/1962 that (I) (we) last saw the deceased alive on 4/21/1962 , and that death occurred at 4:32 M, from the causes and on the date stated above.			
22a. SIGNATURE L. Benedict M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) L. BENEDICT M.D.		22d. ADDRESS CROWNSSVILLE STATE HOSPITAL	
23a. (BURIAL) CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 4--24,62	23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet	23d. LOCATION (City, town or county) (State) Prince Frederick, Md.
24. FUNERAL DIRECTOR'S SIGNATURE Pinckney E. Sowell - Prince Frederick, Md.		25a. REC'D BY REGISTRAR APR 25 '62	
25b. REGISTRAR'S SIGNATURE Arthur S. Harris			

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Christmas State

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Comprehensive Health Survey
Physician's Health Survey
General Health Survey

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TO HOSPITAL death. Page 4 be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

the law requires that the death certificate be executed within 24 hours after death.

the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
04122 CERTIFICATE OF DEATH 04119											
1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Crownsville c. LENGTH OF STAY IN 1b 15 years 2 mos. 13 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Crownsville State Hospital						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland d. STREET ADDRESS Unknown e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Alfred			First Middle Last McQuire			4. DATE OF DEATH 4		Month 11		Day 1962	
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1887		9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor				10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (County & State, or foreign country) Virginia			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Edney Tigney							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Hospital Records		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypostatic Pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (b) Septicemia from Decubital Ulcers (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Chronic Brain Syndrome Associated with Generalized Arteriosclerosis										INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----							
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) -----		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1/28 to 4/11 , 1962, that (I) (we) last saw the deceased alive on 4/11 , 1962, and that death occurred at 6:50 A.M. from the causes and on the date stated above.											
22a. SIGNATURE Hildegard Heard Reissman M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE 4/11/62			
22c. PHYSICIAN'S NAME (Type) Hildegard Heard Reissman, M. D.						22d. ADDRESS Crownsville State Hospital, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal Apr 13, 1962				23b. DATE THEREOF Apr 13, 1962		23c. NAME OF CEMETERY OR CREMATORY of Maryland		23d. LOCATION (City, town or county) (State) Baltimore Ind.			
24. FUNERAL DIRECTOR'S SIGNATURE W. Reed H. Co. 208 W. Ward St. Crownsville, Md.						25a. REC'D BY REGISTRAR APR 17 '62		25b. REGISTRAR'S SIGNATURE Arthur S. Hines			

04113

CERTIFICATE OF DEATH

04113

State of Tennessee
County of Davidson
I, the undersigned, a duly qualified and licensed physician, do hereby certify that on the 11th day of May, 1962, at Nashville, Tennessee, I attended the last illness of
Name of Deceased
and that he died at the age of 18 years, 10 months, and 10 days, of the disease of
Cause of Death
which was caused by
Manner of Death
I, the undersigned, do hereby certify that the above named deceased was at the time of his death a resident of the State of Tennessee, and that he was born on the 11th day of May, 1944, at Nashville, Tennessee.
Signature of Physician
Date

Witness my hand and the seal of the State of Tennessee at Nashville, Tennessee, this 11th day of May, 1962.
Signature of Registrar
Seal of the State of Tennessee
I, the undersigned, a duly qualified and licensed physician, do hereby certify that on the 11th day of May, 1962, at Nashville, Tennessee, I attended the last illness of
Name of Deceased
and that he died at the age of 18 years, 10 months, and 10 days, of the disease of
Cause of Death
which was caused by
Manner of Death
I, the undersigned, do hereby certify that the above named deceased was at the time of his death a resident of the State of Tennessee, and that he was born on the 11th day of May, 1944, at Nashville, Tennessee.
Signature of Physician
Date

Witness my hand and the seal of the State of Tennessee at Nashville, Tennessee, this 11th day of May, 1962.
Signature of Registrar
Seal of the State of Tennessee
I, the undersigned, a duly qualified and licensed physician, do hereby certify that on the 11th day of May, 1962, at Nashville, Tennessee, I attended the last illness of
Name of Deceased
and that he died at the age of 18 years, 10 months, and 10 days, of the disease of
Cause of Death
which was caused by
Manner of Death
I, the undersigned, do hereby certify that the above named deceased was at the time of his death a resident of the State of Tennessee, and that he was born on the 11th day of May, 1944, at Nashville, Tennessee.
Signature of Physician
Date

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04123

04120

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Ma b. COUNTY AA	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1010 Baltimore-Annapolis Blvd. E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Sue Forest Nash		4. DATE OF DEATH Month Day Year April 20 19 62	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 10, 1897
9. AGE (In years last birthday) 65		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Vice President		10b. KIND OF BUSINESS OR INDUSTRY Nash Welding	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Henry Carnes		14. MOTHER'S MAIDEN NAME Mary Jane Nash	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 213-26-3925	
17. INFORMANT Mr. Charles Nash, Sr., same as 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio-sclerotic Cardio-vascular DUE TO Wenckebach (c) Wenckebach INTERVAL BETWEEN ONSET AND DEATH 8 years 5 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 8-18 19 62 to 4-20 19 62 that (I) (we) last saw the deceased alive on 4-18 19 62 and that death occurred at 11A M, from the causes and on the date stated above.			
22a. SIGNATURE C. R. MacDonal M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) C. R. MacDonal 1d, M.D.		22d. ADDRESS 204 Crain Highway SW, Glen Burnie, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF April 24, 62	
23c. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial		23d. LOCATION (City, town, or county) (State) Glen Burnie, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Hopping and Kirkley, Glen Burnie, Md.		25a. REC'D BY REGISTRAR DATE APR 23 '62	
25b. REGISTRAR'S SIGNATURE Arthur S. Thomas			

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John Henry Carter

213-26-1075 Mr. Charles W. H. ...



W. H. Wilson, Jr., M.D.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04124

CERTIFICATE OF DEATH

04121

Item 1 Film G313 5/21/62 iwk

1. PLACE OF DEATH a. COUNTY <u>AA - County</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Crooksville</u> c. LENGTH OF STAY IN 1b <u>2 yrs. 2 mo. 9 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Crooksville State Hosp.</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Howard Elkridge</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>13X-2</u> d. STREET ADDRESS <u>Box - 291A Larkbourn Rd</u> e. IS RESIDENCE ON A FARM? <input type="checkbox"/> YES <input type="checkbox"/> NO			
3. NAME OF DECEASED (Type or print) <u>Mary Lee Nelson</u>				4. DATE OF DEATH Month <u>4</u> Day <u>8</u> Year <u>1962</u>			
5. SEX <u>F.M.</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-9-1894</u>	
9. AGE (In years last birthday) <u>67</u> yrs.		10. IF UNDER 1 YEAR Months <u>4</u> Days <u>8</u> Hours <u>19</u> Min.		11. AGE (In years last birthday) <u>67</u> yrs.		12. IF UNDER 24 HRS. Months <u>4</u> Days <u>8</u> Hours <u>19</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (County & State, or foreign country) <u>Howard County, Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Samuel Kelly</u>				14. MOTHER'S MAIDEN NAME <u>unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>-</u>				16. SOCIAL SECURITY NO. <u>-</u>			
17. INFORMANT <u>According to the Pt's hosp. record.</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart Failure</u> DUE TO (b) <u>Hypertensive heart disease</u> DUE TO (c) <u>Lung Tbc.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>5/3/1961</u> to <u>4/18/1962</u> that (I) (we) last saw the deceased alive on <u>4/18/1962</u> , and that death occurred at <u>11:15</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>[Signature]</u>				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>C. BENEDICT M.D.</u>				22d. ADDRESS <u>Crooksville State Hosp.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4-13-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Odd Fellows -</u>		23d. LOCATION (City, town or county) (State) <u>Elkridge, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>B. L. Sinsender</u>				25a. REC'D BY REGISTRAR <u>APR 12 '62</u>			
ADDRESS <u>Rockville</u>				25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanes</u>			

MEDICAL CERTIFICATION

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate has been signed by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

15110

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Anne Arundel General Hospital</u>		d. STREET ADDRESS <u>Melvin Road</u>	
3. NAME OF DECEASED (Type or print) <u>OLOF CHRISTIAN NELSON</u> <u>Nelson</u>		4. DATE OF DEATH Month <u>April</u> Day <u>13</u> Year <u>19 62</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/23/77</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chauffeur</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Chauffeur</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Sweden</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Pek Nelson</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Mrs Erik N. Olmen</u> <u>Hospital records</u>		Address <u>(2)</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (b) <u> </u> (c) <u> </u> DUE TO (e), stating the underlying cause last. (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 DAYS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u> </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour e.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>4/8</u> , 19 <u>62</u> to <u>4/13</u> , 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>4/13</u> , 19 <u>62</u> , and that death occurred at <u>9:45 P.M.</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Edward Beck</u> M.D.		22b. DATE SIGNED <u> </u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. Edward Beck</u>		22d. ADDRESS <u>Franklin St., Annapolis, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4-16-1962</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>At Home Court</u>		23d. LOCATION (City, town or county) (State) <u>Annapolis Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor Sr</u>		25a. REC'D BY REGISTRAR <u>APR 17 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>		25c. DATE <u>APR 17 '62</u>	

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **04123**

04126

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville c. LENGTH OF STAY IN 1b 24 years 1 mo. 25 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Crownsville State Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 233 N. Amity Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Charles Middle Norris Last Norris				4. DATE OF DEATH Month 4 Day 21 Year 1962			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 5, 1913	
9. AGE (In years last birthday) 48 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Eleanor Parker			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Hospital Records Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchogenic Carcinoma 162.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) 162.1 (c) 162.1 DUE TO cause lost.						INTERVAL BETWEEN ONSET AND DEATH Months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Elmer G. Linhardt, M. D.				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 4/24/62	
EXAMINER'S NAME (Type) Elmer G. Linhardt, M. D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, or REMOVAL (Specify) Burial		22b. DATE THEREOF 4/25/62		22c. NAME OF CEMETERY OR CREMATORY Crownsville State Hospital Burial Grounds		22d. LOCATION (City, town, or county) (State) Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Charles B. Ward, M. D., Superintendent, C.S.H.				24a. REC'D BY REGISTRAR APR 27 '62		24b. REGISTRAR'S SIGNATURE Arthur J. Hume	

MEDICAL CERTIFICATION

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
LAST FIRST MIDDLE		M F		YEARS MONTHS DAYS		MM DD YY		COUNTY STATE		CITY		STATE		COUNTRY	
RACE															
EDUCATION															
OCCUPATION															
MARITAL STATUS															
RELIGION															
DATE OF DEATH															
PLACE OF DEATH															
CITY OF DEATH															
STATE OF DEATH															
COUNTRY OF DEATH															
CAUSE OF DEATH															
MANNER OF DEATH															
SIGNATURE OF EXAMINER															
DATE OF EXAMINATION															
PLACE OF EXAMINATION															
CITY OF EXAMINATION															
STATE OF EXAMINATION															
COUNTRY OF EXAMINATION															
FAMILY HISTORY															
SOCIAL HISTORY															
PHYSICAL HISTORY															
LABORATORY TESTS															
X-RAY															
AUTOPSY															
OTHER															



TO HOSPITAL, CLINIC, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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04127
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04124
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Pasadena (Bar Harbor)		c. LENGTH OF STAY IN 1b 3 yrs.		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Pasadena (Bar Harbor)			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 60 Johnson Road				d. STREET ADDRESS 60 Johnson Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Martin Joseph O'Connor				4. DATE OF DEATH APRIL 13 1962		Month Day Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 6, 1886		9. AGE (In years last birthday) 76 yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printer		10b. KIND OF BUSINESS OR INDUSTRY Printing		11. BIRTHPLACE (County & State, or foreign country) Ireland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Owen O'Connor				14. MOTHER'S MAIDEN NAME Margaret Conroy			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 212-03-8753		17. INFORMANT Mrs. Onna O'Connor		Address Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) TERMINAL BRONCHO-PNEUMONIA DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) GENERALIZED CARCINOMATOSIS DUE TO (c) CARCINOMA SIGMOID						INTERVAL BETWEEN ONSET AND DEATH 48 HOURS 6 MONTHS 4 YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from MARCH 1959 to APRIL 1962 that (I) (was) last saw the deceased alive on APRIL 12 1962 and that death occurred at 1020 AM , from the causes and on the date stated above.							
22a. SIGNATURE Arthur Lankford Jr.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 4-13-62	
22c. PHYSICIAN'S NAME (Type) ARTHUR LANKFORD JR.				22d. ADDRESS MOUNTAIN RD. PASADENA, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF April 16, 1962		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Pk.		23d. LOCATION (City, town or county) (State) Glen Burnie, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE George W. Gonce		ADDRESS 4001 Ritchie Hwy. (25)		25a. REC'D BY REGISTRAR APR 17 '62		25b. REGISTRAR'S SIGNATURE Arthur L. Gonce	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 is to be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04128
CERTIFICATE OF DEATH

04125

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Crownsville c. LENGTH OF STAY IN 1b 1 mo. 7 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Crownsville State Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 1045 N. Kenwood Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lillian Middle B. Last Perrin		4. DATE OF DEATH Month 4 Day 15 Year 1962	
5. SEX Female		6. COLOR OR RACE Negro	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> Sep.		8. DATE OF BIRTH September 4, 1934 9. AGE (In years last birthday) 27 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Barnes		14. MOTHER'S MAIDEN NAME Bessie Spell	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fatty Degeneration of Liver DUE TO Conditions, if any, which gave rise to immediate cause (b) Chronic Alcoholism (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Brain Syndrome Associated with Convulsive Disorder		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----	
20c. TIME OF INJURY Month, Day, Year Hour e.m. ----- 19 p.m. -----		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State) -----	
21. I certify that (I) (this hospital) attended the deceased from 3/8 , 19 62 , to 4/15 , 19 62 , that (I) (we) last saw the deceased alive on 4/15 , 19 62 , and that death occurred at 2:15 P. , from the causes and on the date stated above.			
22a. SIGNATURE [Signature]		22b. DATE 4/16/62	
22c. PHYSICIAN'S NAME (Type) L. Benedict, M. D.		22d. ADDRESS Crownsville State Hospital, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-20-62	
23c. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cemetery		23d. LOCATION (City, town or county) (State) Anne Arundel Co. Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Randolph Collick		25a. REC'D BY REGISTRAR APR 18 '62	
ADDRESS 1412 E. Preston		25b. REGISTRAR'S SIGNATURE Arthur L. Hume	

01152

CERTIFICATE OF DEATH

1918

111

State of Tennessee
County of Davidson
I, the undersigned, a duly qualified and licensed physician, do hereby certify that on the 11th day of September, 1918, at Nashville, Tennessee, I attended the body of
Name of Deceased
Age
Sex
Race
Color
Cause of Death
Died at
Residence of Deceased
Name of Physician
Signature of Physician
Date of Death
Place of Death
City of Death
County of Death
State of Death

Witness my hand and the seal of my office this 11th day of September, 1918.
Signature of Physician
Seal of Office
My Commission Expires on the 11th day of September, 1919.
Signature of Registrar
Seal of Office
My Commission Expires on the 11th day of September, 1919.

Attest:
Signature of Registrar
Seal of Office
My Commission Expires on the 11th day of September, 1919.

Witness my hand and the seal of my office this 11th day of September, 1918.
Signature of Registrar
Seal of Office
My Commission Expires on the 11th day of September, 1919.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 shall be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04126

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Crownsville c. LENGTH OF STAY IN 1b 24 years 8 mos. 9 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Crownsville State Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 1029 Lanvale Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Kelsir		4. DATE OF DEATH Month 4 Day 14 Year 1962					
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1910	9. AGE (In years last birthday) 51 yrs.	IF UNDER 1 YEAR Months 51 Days 14 Hours 14 Min. 1962		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (County & State, or foreign country) Maryland			
13. FATHER'S NAME William Phillips			14. MOTHER'S MAIDEN NAME Addie Holsew				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Hospital Records Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pulmonary Hypertension DUE TO (c) ----- PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Schizophrenic Reaction, Paranoid Type					INTERVAL BETWEEN ONSET AND DEATH 		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----					
20c. TIME OF INJURY Month, Day, Year Hour a.m. ----- p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ----- 20f. (City or town) (County) (State) -----			
21. I certify that (I) (this hospital) attended the deceased from 8/5 , 19 37 to 4/14 , 19 62 , that (I) (we) last saw the deceased alive on 4/14 , 19 62 , and that death occurred at 12:32 A.M. , from the causes and on the date stated above.							
22a. SIGNATURE <i>L. Benedict</i>		22b. DATE 4/16/62		22c. PHYSICIAN'S NAME (Type) L. Benedict, M. D.			
22d. ADDRESS Crownsville State Hospital, Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF April 18/62		23c. NAME OF CEMETERY OR CREMATORY U. of Maryland Crmt. Baltimore, Md.			
23d. LOCATION (City, town or county) (State) Baltimore, Md.							
24. FUNERAL DIRECTOR'S SIGNATURE <i>W. Deesett</i>		25a. REC'D BY REGISTRAR PR 3 0 '62		25b. REGISTRAR'S SIGNATURE <i>Arthur L. Hume</i>			

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-2018-

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04130 CERTIFICATE OF DEATH 04127

1. PLACE OF DEATH a. COUNTY MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNA POLIS c. LENGTH OF STAY IN 1b 53 YRS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ANNA RUNDLE HOSPT				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ANNA RUNDLE c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X SHADY SIDE d. STREET ADDRESS NONE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) ANNE STELLA PROCHAZKA				4. DATE OF DEATH APRIL 7th 1962			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-5-1892	
9. AGE (In years last birthday) 70 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work		11. BIRTHPLACE (County & State, or foreign country) Czechoslovakia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frank Bednarik				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 599-30-8005		17. INFORMANT daughter Mrs Ann M Simmons Address daughter			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhagic broncho pneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. } DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1) Salivary bacterial endocarditis - multiple emboli 2) Cancer of pancreas & metastases							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20c. TIME OF INJURY Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from 4/6/62 to 4/7/62 , that (I) (we) last saw the deceased alive on 4/7/62 , and that death occurred at 11:00 AM from the causes and on the date stated above.							
22a. SIGNATURE f. Church M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 4/8/62		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) GEORGE CHURCH				22d. ADDRESS 121 Cathedral St, Annapolis Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-10-62		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City, town or county) Seotland Md. (State) _____	
24. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers ADDRESS 517-11th St SE, Wash D.C.				25a. REC'D BY REGISTRAR APR 12 '62		25b. REGISTRAR'S SIGNATURE Arthur L. Hume	

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TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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VR A15 (4)
15M 9/60

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04128

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) e. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brooklyn Park				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brooklyn Park			
c. LENGTH OF STAY IN 1b 10 yrs.				d. STREET ADDRESS 201 1/2 Fifth Ave.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 201 1/2 Fifth Ave.							
3. NAME OF DECEASED (Type or print) ALDORA LOUISE PUMPHREY				4. DATE OF DEATH April 21, 19 62			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Mar 24, 1894	
9. AGE (In years last birthday) 67 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME James Claytor				14. MOTHER'S MAIDEN NAME Margaret A. Spreel			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. (If yes give number or date of service)			
17. INFORMANT Mrs. Elizabeth L. Colliflower				Address Same			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 420.1 DUE TO Coronary artery disease. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus							
INTERVAL BETWEEN ONSET AND DEATH							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from Feb 2, 1960 to Apr 21, 1962 , that (I) (we) last saw the deceased alive on April 19, 1962 , and that death occurred 10:55 A.M. from the causes and on the date stated above.							
22a. SIGNATURE Morton M. Krieger				22b. DATE SIGNED April 23, 1962			
22c. PHYSICIAN'S NAME (Type) Morton M. Krieger M.D.				22d. ADDRESS 5010-A Gov. Ritchie Hwy. Balte. 25, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF April 24, 1962		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Pk.		23d. LOCATION (City, town or county) (State) Glen Burnie, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE George J. Gence				25a. REC'D BY REGISTRAR APR 27 '62			
ADDRESS 4001 Ritchie Hwy. (25)				25b. REGISTRAR'S SIGNATURE William S. Thane			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04129

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE Maryland b. COUNTY Anne Arundel		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 1		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millersville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital			d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Nathaniel Middle A. Last Pumphrey			4. DATE OF DEATH Month April Day 2 Year 19 62		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/29/87	9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer (ret.)		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (County & State, or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S. A.			13. FATHER'S NAME Benjamin Pumphrey		
14. MOTHER'S MAIDEN NAME Minnie Meyers			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		
16. SOCIAL SECURITY NO. unknown			17. INFORMANT Mrs. Natalie Thummel Address Hospital records		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Posterior x Anterior Myocardial infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 420.1 DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 5 Day INTERVAL BETWEEN ONSET AND DEATH			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from 3-29-62 to 4-2-62 that (I) (we) last saw the deceased alive on 4-1-62 , and that death occurred 3:55A from the causes and on the date stated above.					
22a. SIGNATURE Frank Shipley			22b. DATE SIGNED 4-2-62		
22c. PHYSICIAN'S NAME (Type) Dr. Frank Shipley			22d. ADDRESS Cathedral St., Annapolis, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5th April '62		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Park	
23d. LOCATION (City, town or county) Glen Burnie, Md.		23e. (State) Md.		23f. (Country) U.S.A.	
24. FUNERAL DIRECTOR'S SIGNATURE Singleton, Thomas W.			25a. REC'D BY REGISTRAR Glen Burnie, Md.		
25b. REGISTRAR'S SIGNATURE Arthur L. Kraus			25c. DATE APR 5 '62		

01153

CERTIFICATE OF DEATH

1132

John Smith

Married

Age 45 years 1 month 10 days

Residence

John Smith

John Smith

Married

John Smith

John Smith

John Smith

John Smith

John Smith

John Smith

John Smith

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
04133					04130				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, If Institution; Residence before admission)				
a. COUNTY		Anne Arundel			a. STATE		b. COUNTY		
		MARYLAND			Maryland		Anne Arundel		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				
Annapolis					10 Annapolis				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Anne Arundel General Hospital					Bay Ridge Road				
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH				
First Middle Last					Month Day Year				
Vernon A. QUADE					April 17 1962				
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)	
Male		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Oct. 17, 1894		67 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)			12. CITIZEN OF WHAT COUNTRY?	
Carpenter			Self-employed		Maryland			U.S.	
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
Herman A. Quade					Alice Estelle Crutchley				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT				
NO					Rudolph V. Quade Annapolis Md				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)									
443X DUE TO Azotemia									
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) Cerebro-Vascular Thrombosis									
DUE TO (c) Hypertensive Cerebro-Vascular Disease									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year			20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)
Hour a.m. p.m.			While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work						
19									
21. I certify that (I) (M.D. or P.D.) attended the deceased from Feb. 13, 1962 to Apr. 17, 1962, that (I) (X) last saw the deceased alive on Apr. 17, 1962, and that death occurred at 6:05 PM M. from the causes and on the date stated above.									
22a. SIGNATURE					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED		
James R. Martin					M.D.		4-18-62		
22c. PHYSICIAN'S NAME (Type)					22d. ADDRESS				
James R. Martin, M.D.					6 Shaw St., Annapolis, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county)		(State)
Burial			4-20-1962		Cedar Bluff Cem.		Annapolis		Md.
24. FUNERAL DIRECTOR'S SIGNATURE					ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE
John M. Taylor					Son Annapolis Md		DATE APR 23 '62		Arthur S. Kline

04133

04130

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
Item 7 Film G313 5/17/62 mh										
Reg. Dist. No.										
1. PLACE OF DEATH a. COUNTY <i>A.A. Co.</i> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>A.A. Co.</i>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>					c. LENGTH OF STAY IN 1b					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X Arnold</i>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>D.O.R. Annapolis - Maryland</i>					d. STREET ADDRESS					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <i>William A Richards</i>					4. DATE OF DEATH Month Day Year <i>4 2 1962</i>					
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 6, 1935</i>		9. AGE (In years last birthday) <i>26 yrs.</i>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Truck Driver</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>Hauling</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>			
13. FATHER'S NAME <i>Grover Richards</i>					14. MOTHER'S MAIDEN NAME <i>Madeline Smelter</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>yes 1959</i>			16. SOCIAL SECURITY NO. <i>217-30-5329</i>		17. INFORMANT Address <i>Louise M. Richards 407 Kingwood Rd.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Multiple Injuries -</i> DUE TO <i>825X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Auto accident involving line truck</i>							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>9 4/2/ 1962</i>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Highway</i>		20f. (City or town) (County) (State) <i>A.A. Co. MD</i>			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .										
ACTUAL SIGNATURE <i>E. Linhardt</i>					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>					DATE SIGNED <i>4.2.62</i>
EXAMINER'S NAME (Type) <i>E. Linhardt</i>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>4/6/62</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Baltimore National Cem.</i>			22d. LOCATION (City, town, or county) (State) <i>Baltimore Maryland</i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Amber Inc. 1324 Saylor Spring Rd.</i>					24a. REC'D BY REGISTRAR DATE <i>APR 6 '62</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Prater</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04135

CERTIFICATE OF DEATH

Reg. Dist. No. 04132

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>—</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort George G. Meade</u>		c. LENGTH OF STAY IN 1b <u>—</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>KIMBROUGH ARMY HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>DERRY</u> Middle <u>L</u> Last <u>RICHARDSON</u>		4. DATE OF DEATH Month <u>APRIL</u> Day <u>1</u> Year <u>1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 15, 1962</u>
9. AGE (In years lost birthday) yrs. <u>2</u>		10. IF UNDER 1 YEAR Months <u>2</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Derry L Richardson</u>		14. MOTHER'S MAIDEN NAME <u>Phyllis Talley</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Derry J. Richardson Sr.</u>		Address <u>1825 Penrose Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Meningitis</u> 340.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u>—</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>31 Mar</u> , 19 <u>62</u> , to <u>1 Apr</u> , 19 <u>62</u> , that I last saw the deceased alive on <u>1 Apr</u> , 19 <u>62</u> , and that death occurred at <u>5:15 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Stuart Bernstein</u> M.D.		ADDRESS (Street, city or town, state) <u>Kimbrough Army Hospital</u> DATE SIGNED <u>1 Apr 62</u>	
PHYSICIAN'S NAME (Type) <u>STUART BERNSTEIN, Capt., M.C. Kimbrough AH Ft Geo G. Meade, Md.</u>			
22a. BURIAL, CREMATION, or other disposition (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Apr. 4, 1962</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Balto National Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Mrs. Katie R. Walkers</u>		ADDRESS <u>322 N. Schroeder St.</u>	
24a. REC'D BY REGISTRAR <u>PR 4 '62</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Thane</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04133

1. PLACE OF DEATH a. COUNTY Anne Arundel Co. MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena				c. LENGTH OF STAY IN 1b 2 yrs.			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 4 Schwartz Drive				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) CHARLES RICHARD ROBINSON				4. DATE OF DEATH April 3, 1962			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 22, 1895		9. AGE (In years last birthday) 66 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist			10b. KIND OF BUSINESS OR INDUSTRY G. & E. Co.		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.
13. FATHER'S NAME William Robinson				14. MOTHER'S MAIDEN NAME Katherine Wise			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 212-05-4567		17. INFORMANT Mrs. Margaret B. Robinson		Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 157X DUE TO (b) Malnutrition Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) Metastatic Ca of Head of Pancreas PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH 3 mos. 6 mos. 1 yr.
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that (I) (the hospital) attended the deceased from 10/10 , 19 61 , to 4/3 , 19 62 , that (I) (we) last saw the deceased alive on 4/2 , 19 62 , and that death occurred at 11:30 AM , from the causes and on the date stated above.							
22a. SIGNATURE C. Earl Hill M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 4/3/62	
22c. PHYSICIAN'S NAME (Type) C. EARL HILL				22d. ADDRESS 3708 Mountain Rd. Pasadena, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF April 6, 1962		23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem.		23d. LOCATION (City, town or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE George J. Gonce				ADDRESS 4001 Ritchie Hwy. (25)		25a. REC'D BY REGISTRAR APR 4 '62	
				25b. REGISTRAR'S SIGNATURE Arthur S. Thomas			

George J. Gonce

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate is to be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60



3 Dec
6 Dec

Cooperative Wheat Farmers
Administration
Institute Co of Wheat Farmers

10/10 11/10 12/10
1/10 2/10 3/10
4/10 5/10 6/10
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PEARL HILL
of Pearl Hill

1001 BIRCH ST. (25)
1001 BIRCH ST. (25)

VS. A15ME
5M 9/60

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Anne Arundel

(Royal) Hanover, Md.

Don Brooks-Jackson Co-Ed

John

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Conway

April 22 63

Md.

Baltimore

Carbon monoxide poisoning.

X

(Ed) in closed out with base checked to expand

(Ed)

Apr. 28 63

X

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Hanover, Anne Arundel Md.

Hanover 2100
Howard 2100

X

Apr. 29 63

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04138

CERTIFICATE OF DEATH

Item 9 Film G311 4/16/62 mh

04134

1. PLACE OF DEATH a. COUNTY AA MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY AA			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Brooklyn, Md				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Brooklyn Pk.			
c. LENGTH OF STAY IN 1b				d. STREET ADDRESS 315 15th Ave			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 315 15th Ave				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) ELMER ROGERS				4. DATE OF DEATH Month 4 Day 11 Year 1962			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 28, 1910		9. AGE (In years last birthday) 51	IF UNDER 1 YEAR Months 50 Days 15	IF UNDER 24 HRS. Hours 15 Min. 00
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sta. Eng. Olin Mat. Co				10b. KIND OF BUSINESS OR INDUSTRY Md.		11. BIRTHPLACE (County & State, or foreign country)	
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME Eli Rogers			
14. MOTHER'S MAIDEN NAME Kath. Lowry				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or date of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT Family		Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 157X DUE TO Carcinoma of Pancreas Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							INTERVAL BETWEEN ONSET AND DEATH 6 mo.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)				20g. (County)			
20h. (State)				21. I certify that (I) (this hospital) attended the deceased from....., 19....., to....., 19....., that (I) (we) last saw the deceased alive on....., 19....., and that death occurred at.....M, from the causes and on the date stated above.			
22a. SIGNATURE P. J. Ginnaldi M.D.				22b. DATE SIGNED 4-11-62			
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS 4609 Gov. Ritchie Highway			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 4/11/62			
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill				23d. LOCATION (City, town or county) (State) Balto., Md.			
24. FUNERAL DIRECTOR'S SIGNATURE McCully Funeral Homes 130 E. Fort Ave.				25a. REC'D BY REGISTRAR DATE APR 13 '62			
25b. REGISTRAR'S SIGNATURE Charles S. House							

TO HOSPITAL. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

01133

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RECEIVED FOR DEPOSIT

PAID BY BANK OF AMERICA
NEW YORK, N.Y.

RECEIVED FOR DEPOSIT

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04139

04135

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN Ib 2 days	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Anne Arundel General Hospital		X d. STREET ADDRESS Rt-2, Box-482	
3. NAME OF DECEASED (Type or print) Baker H SEEDERS		4. DATE OF DEATH April 23 19 62	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 19, 1871
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY Unknown	
11. BIRTHPLACE (County & State, or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 481X IMMEDIATE CAUSE (a) Influenza DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) 481X DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Coronary of prostate	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) deceased attended the deceased from 4 20 62 , to Apr. 22, 19 62 , that (I) was last saw the deceased alive on Apr. 22, 19 62 , and that death occurred at 1:05 AM , from the causes and on the date stated above.			
22a. SIGNATURE G. Blum		22b. DATE SIGNED 4/24/62	
22c. PHYSICIAN'S NAME (Type) G. E. H. W. A. H.		22d. ADDRESS 121 Cathedral St., Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF April 25, 62	
23c. NAME OF CEMETERY OR CREMATORY Mt Zion Cemetery		23d. LOCATION (City, town or county) (State) Lothian, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home		25a. REC'D BY REGISTRAR APR 27 '62	
ADDRESS Annapolis, Md.		25b. REGISTRAR'S SIGNATURE C. L. K. K.	

7-2132

01132

Anna Arnold

Harland

Anna Arnold

Unknown

2 days

Local - Unknown

Anna Arnold General Hospital

10-2, 10-3

after

2 days

10-3

10-3

White

Oct. 10, 1917

10-3

Unknown

West Virginia

U.S.

Unknown

Unknown

no

Hospital Records

Apr. 22, 1918

10-3

Apr. 22, 1918

General Hospital, West Virginia

Apr. 22, 1918

General Hospital, West Virginia

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04140
04136
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Anne A undel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN lb 6 hrs.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Anne A undel General Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 10 Annapolis	
3. NAME OF DECEASED (Type or print) ZORA GRAY SISCOE		d. STREET ADDRESS 59 Calvert St.,	
5. SEX Female		4. DATE OF DEATH April 3 19 62	
6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH April 3, 1900	
7. MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) 62 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laundress		10b. KIND OF BUSINESS OR INDUSTRY Gov. Mansion	
11. BIRTHPLACE (County & State, or foreign country) Maryland - Annapolis		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME George Snowden		14. MOTHER'S MAIDEN NAME Rachel W. Wooten	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-12-7715	
17. INFORMANT Patricia B. Wallace		Address -59 Calvert St. Anna. Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Cerebral Hemorrhage Rt. Side 331X DUE TO Conditions, if any, which gave rise to immediate cause (b) Hypertensive Sclerotic Disease (c) DUE TO cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH 3 hr. 10 yr.		19. WAS AUTOPSY PERFORMED? YES XXXX NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour e.m. Month, Day, Year p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) DECEASED attended the deceased from 4/2/62 19....., to 4/9/62 19....., that (I) was saw the deceased alive on April 3, 19 62 , and that death occurred at 12:45 AM from the causes and on the date stated above.			
22a. SIGNATURE Thermon N. Johnson M.D.		22b. DATE SIGNED 4/3/62	
22c. PHYSICIAN'S NAME (Type) T. H. Johnson, M.D.		22d. ADDRESS 37 Calvert St., Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF April 6-62	
23c. NAME OF CEMETERY OR CREMATORY Brewer Hill		23d. LOCATION (City, town or county) (State) Annapolis, Md.	
24 FUNERAL DIRECTOR'S SIGNATURE C.E.Hicks III		25a. REC'D BY REGISTRAR APR 6 '62	
ADDRESS Annapolis, Md.		25b. REGISTRAR'S SIGNATURE Arthur L. Kline	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate is to be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

1
04141
MAYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04137
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 3 hrs.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Anne Arundel General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Alice Middle Ann Mae (EVANS) Last SMITH		4. DATE OF DEATH Month April Day 12 Year 19 62	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Feb. 28, 1918
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		9b. KIND OF BUSINESS OR INDUSTRY Own Home	9. AGE (In years last birthday) 44 yrs.
10a. CITIZEN OF WHAT COUNTRY? USA		11. BIRTHPLACE (County & State, or foreign country) Marion, S.E.	
13. FATHER'S NAME Clem Evans		14. MOTHER'S MAIDEN NAME Alice Marie Smith	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs Shirley Ann Stanley-Daughter- same as # 2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) General Carcinomatous DUE TO Carcinoma of stomach Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c)		INTERVAL BETWEEN ONSET AND DEATH 4 mos +	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the physician) attended the deceased from April 12, 1962 to Apr. 12, 1962 , that (I) (the physician) saw the deceased alive on Apr. 12, 1962 , and that death occurred at 2:55 PM from the causes and on the date stated above.			
22a. SIGNATURE Maurice Klawans M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED 4/13/62	
22c. PHYSICIAN'S NAME (Type) Maurice Klawans		22d. ADDRESS 31 Southgate Ave., Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF April 16, 1962	
23c. NAME OF CEMETERY OR CREMATORY Oaklawn Cemetery		23d. LOCATION (City, town or county) (State) Charlotte, North Carolina	
24. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home		25a. REC'D BY REGISTRAR DATE APR 17 '62	
ADDRESS Annapolis, Maryland		25b. REGISTRAR'S SIGNATURE Arthur S. Krawns	

01137

STATEMENT OF DEATH

1917

State of New York
County of New York
I, the undersigned, a Justice of the Peace for the County of New York, do hereby certify that the within and foregoing is a true and correct copy of the statement of death of the person named therein, as the same appears from the records of the County of New York, and that the same is a true and correct copy of the statement of death of the person named therein, as the same appears from the records of the County of New York.

Witness my hand and the seal of the County of New York, at New York, this 1st day of January, 1917.

Justice of the Peace for the County of New York

Notary Public for the County of New York

TO HOSPITAL, ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 6 be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04142
Item 8 FilmG312 5/2/62 jwk
04138

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 1 day	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS Rt-1, Box-433	
3. NAME OF DECEASED (Type or print) Charles SMITH		4. DATE OF DEATH April 30 1962	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 17, 1900
9. AGE (In years last birthday) 61 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Guard		10b. KIND OF BUSINESS OR INDUSTRY Naval Station	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Robert Smith		14. MOTHER'S MAIDEN NAME Eva (unknown)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) yes WW 1		16. SOCIAL SECURITY NO. 705 12 4007	
17. INFORMANT Mrs. Isable Kursch		Address Glen Burnie, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute peritonitis 542.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Perforated jejunal ulcer opposite old gastro-jejunal Anastomosis (c) Digestive Tract disorder for many years		INTERVAL BETWEEN ONSET AND DEATH 48 hrs. 48 hrs. 2 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Digestive Tract disorder for many years		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (was) attended the deceased from April 29, 1962 to Apr. 30, 1962 , that (I) (was) last saw the deceased alive on Apr. 30, 1962 , and that death occurred at 11:55 PM from the causes and on the date stated above.			
22a. SIGNATURE Merton T. Waite		22b. DATE SIGNED 5-1-62	
22c. PHYSICIAN'S NAME (Type) Merton T. Waite, M.D.		22d. ADDRESS 121 Cathedral St., Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4th May 1962	
23c. NAME OF CEMETERY OR CREMATORY Baltimore Nat'l. Cem.		23d. LOCATION (City, town or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Richard V. Singleton		25. REC'D BY REGISTRAR MAY 3 '62	
ADDRESS Glen Burnie, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

04138

04138

NAME - [illegible]

NAME - [illegible]

NAME - [illegible]

UNIT - [illegible]

1 day

UNIT - [illegible]

NO. 1, [illegible]

UNIT - [illegible]

30

April

1950

UNIT - [illegible]

Dec. 17, 1950

UNIT - [illegible]

UNIT - [illegible]

U.S.

UNIT - [illegible]

UNIT - [illegible]

UNIT - [illegible]

Ev. (unseen)

UNIT - [illegible]

[illegible text]

[illegible text]

[illegible text]

[illegible text]

[illegible text]

[illegible text]

[illegible text]

[illegible text]

[illegible text]

[illegible text]

[illegible text]

[illegible text]

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04143

04139

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) ANNAPOLIS c. LENGTH OF STAY IN lb ANNAPOLIS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) USNH ANNAPOLIS, MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. MARYLAND b. COUNTY ANNE ARUNDEL c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS d. STREET ADDRESS 200 SEVERN AVENUE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last SAMUEL WILLIAM SMITH		4. DATE OF DEATH Month Day Year APRIL 17 1962	
5. SEX MALE	6. COLOR OR RACE CAUC	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 21 DEC 1865
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MSGT		10b. KIND OF BUSINESS OR INDUSTRY U.S. MARINE CORPS	9. AGE (In years last birthday) 96 yrs.
11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? UNITED STATES	
13. FATHER'S NAME GEORGE A. SMITH		14. MOTHER'S MAIDEN NAME MARY EVA WILL	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES 1887-1918		16. SOCIAL SECURITY NO. none	
17. INFORMANT MARY E. SPRINGFIELD 718 MONTEREY AVE. ANNA MD		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY INFARCTION. 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) INANITION DISEASE. (c), stating the underlying cause last. ARTERIOSCLEROTIC HEART DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) HYPOPROTEINEMIA - PNEUMONIA.		INTERVAL BETWEEN ONSET AND DEATH 24 HRS. YEARS. YEARS.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3/9/62 to 1/17/62, that (I) (we) last saw the deceased alive on 19.62, and that death occurred at 5:30 M. from the causes and on the date stated above.			
22a. SIGNATURE E.C. KEENE		22b. DATE 17 APR 62	
22c. PHYSICIAN'S NAME (Type) E.C. KEENE M.D.		22d. ADDRESS U S N H Annapolis, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF April 20, 1962	
23c. NAME OF CEMETERY OR CREMATORY St Anne's Cemetery		23d. LOCATION (City, town or county) (State) Annapolis, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home		25a. REC'D BY REGISTRAR DATE APR 23 '62	
25b. REGISTRAR'S SIGNATURE Arthur S. Frank			

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5. 3. 1. 1.

21 JYANUARY

1992-2001

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31 DEC 1965

MARY EVA WILL

RAY, E. SPRINGFIELD 118 MONTEREY AVE. ANN AR

ACCEPTED

1994-1995

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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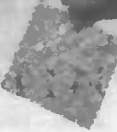
2

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04144 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 04140

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>		c. LENGTH OF STAY IN 1b <u>Few hours</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Landsdowne</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>First Aid Room, Laurel Race Track</u>				d. STREET ADDRESS <u>27 Hazel Ave.</u>			
3. NAME OF DECEASED (Type or print) <u>Charles Davis Solloway Sr.</u>				4. DATE OF DEATH <u>April 17</u> 19 <u>62</u>			
5. SEX <u>M.</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6/7/10</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Watchman for Monumental Life Insurance Co.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Laurel Race Track</u>		9. AGE (In years last birthday) <u>51</u> yrs.		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John E. Solloway</u>				14. MOTHER'S MAIDEN NAME <u>Mary Stewart</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Navy 1p26-29</u>				16. SOCIAL SECURITY NO. <u>705-09-6540</u>			
17. INFORMANT <u>Charles Davis Solloway Jr. (son)</u>				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Gustave H. Faubert, M.D.</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>4/17/62</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)				22b. DATE THEREOF <u>4-20-62</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>GLEN HOLLOWAY</u>				22d. LOCATION (City, town, or country) (State) <u>Glen Lurnie, Md.</u>			
23. FUNERAL DIRECTOR <u>McFadyen - 130 E Fort St.</u>				24. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE <u>Wm. L. Thomas</u>			



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CERTIFICATE OF DEATH

Reg. Dist. No. 04141

04145

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ft. Meade Md.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Ft. George G. Meade.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>KIMBOROUGH ARMY HOSPITAL</u>				d. STREET ADDRESS <u>4525 BUTLER ST.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>JEANNETTE</u> First <u>SPENCER.</u> Middle Last				4. DATE OF DEATH Month <u>4</u> Day <u>20</u> Year <u>1962</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>CAUC</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>SEPT 4, 1885</u>	
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>PHILADELPHIA PA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Chas. W. Klauder</u>				14. MOTHER'S MAIDEN NAME <u>Jane Cascaden</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>—</u>		INFORMANT <u>Col. THOMAS C. SPENCER</u> Address <u>4523 BUTLER ST. FT. MEADE, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u> <u>331</u> X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause (c): (b) <u>Cerebral arteriosclerosis</u> (c) <u>Generalized arteriosclerosis</u> Interval between ONSET AND DEATH <u>15 days</u> <u>Unknown</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pneumonia</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>20 April</u> , 19 <u>62</u> , to <u>20 April</u> , 19 <u>62</u> , that I last saw the deceased alive on <u>20 April</u> , 19 <u>62</u> , and that death occurred at <u>5 P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William W. Mears</u>				M.D. <u>Kimborough Army Hospital</u> <u>20 April 1962</u>			
PHYSICIAN'S NAME (Type) <u>WILLIAM W. MEARS.</u>				ADDRESS (Street, city or town, state) <u>Ft. George G. Meade, Md.</u> DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>Apr 21, 1962</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Crematory</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Va</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Halliday</u> ADDRESS <u>530 WASH BLVD Md</u>				24a. REC'D BY REGISTRAR DATE <u>APR 25 '62</u>			
				24b. REGISTRAR'S SIGNATURE <u>Clifford E. H...</u>			

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CERTIFICATE OF DEATH

60145

[Faint, illegible text, likely bleed-through from the reverse side of the document. The text appears to be a form with various fields and possibly a signature at the bottom.]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 041142

04146

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>A.A. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c. LENGTH OF STAY IN 1b <u>X MILLERSVILLE</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>A.A. GENERAL Hospital</u>		d. STREET ADDRESS <u>Box 77</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Lila</u> First <u>Stamp</u> Middle <u>Stamp</u> Last		4. DATE OF DEATH Month <u>4</u> Day <u>29</u> Year <u>1962</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-14-1905</u>
9. AGE (In years last birthday) <u>56</u> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William COCHRAN</u>		14. MOTHER'S MAIDEN NAME <u>NANNIE Williams</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Louis M. Stamp</u>		Address <u>#2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>434.4 Cerebral</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Stroke</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <u>[Signature]</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>F. Linhart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <u>A</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>5-2-62</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>GLEN HAVEN</u>		22d. LOCATION (City, town, or county) (State) <u>GLEN BURIE MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 2 '62</u>	
		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01115



Form with multiple sections for medical examination and death certification, including fields for name, date, time, and cause of death.

NAME: _____

DATE: _____

TIME: _____

PLACE: _____

CAUSE OF DEATH: _____

DETAILS OF DEATH: _____

SIGNATURE: _____

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04143

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN 1b <u>10</u> <u>Annapolis</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Anne Arundel General Hospital</u>				d. STREET ADDRESS <u>111 Academy Street</u>			
3. NAME OF DECEASED (Type or print) <u>James J. Stehle</u>				4. DATE OF DEATH Month <u>April</u> Day <u>28</u> Year <u>1962</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct 11, 1880</u>	
9. AGE (In years last birthday) <u>81</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Self-employed</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Stehle Equipment Co.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Annapolis Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Frederick W. Stehle</u>		14. MOTHER'S MAIDEN NAME <u>Augusta Spies</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Spanish Am.</u>	
16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Hospital Records</u>		18. CAUSE OF DEATH (Enter only one cause for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Peripheral embolization</u> DUE TO (b) <u>Arteriosclerotic cordis vascular disease</u> (c) <u>—</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u> <u>several yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>—</u> e.m. <u>—</u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) <u>Annapolis</u> <u>Md</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>4-21</u> <u>1962</u> to <u>4-28</u> <u>1962</u> , that (I) (we) last saw the deceased alive on <u>4-27</u> <u>1962</u> , and that death occurred at <u>8:15</u> <u>AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Barber C. Palmer Jr.</u>				22b. DATE SIGNED <u>4-28-62</u>		22c. PHYSICIAN'S NAME (Type) <u>Dr. Barber C. Palmer</u>	
22d. ADDRESS <u>77 Franklin St. Annapolis, Maryland</u>				23a. REC'D BY REGISTRAR DATE <u>MAY 2 '62</u>			
23b. REGISTRAR'S SIGNATURE <u>Arthur L. Thorne</u>				23c. NAME OF CEMETERY OR CREMATORY <u>St Marys Cem</u>			
23d. LOCATION (City, town or county) <u>Annapolis</u>				23e. (State) <u>Md</u>			
23f. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23g. DATE THEREOF <u>Apr 30th 62</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Scyler Sns</u>				24b. ADDRESS <u>Annapolis Md.</u>			

01113

UNITED STATES OF AMERICA

UNIT



Anna Arnold

Harvard

Anna Arnold

Harvard

Harvard

Anna Arnold General Hospital

Harvard General Hospital

James

James

April 20

1901

Self-c. Levy

People's Equipment Co.

Harvard General Hospital

Harvard General Hospital

Harvard General Hospital

Dr. R. S. Palmer

Dr. R. S. Palmer

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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04148

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04144

1. PLACE OF DEATH a. COUNTY <i>A. A.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, or institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>A. A.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Odenton</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Admiral General Hospital</i>		d. STREET ADDRESS <i>1</i>	
3. NAME OF DECEASED (Type or print) <i>Nathanial Stevenson</i>		4. DATE OF DEATH Month <i>4</i> Day <i>6</i> Year <i>1962</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Col</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>4-7-1897</i>
9. AGE (In years last birthday) <i>64</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Phillip Stevenson</i>		14. MOTHER'S MAIDEN NAME <i>Lucy Stevenson</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Blanche Stevenson Odenton Md</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Ruptured aortic aneurysm</i> <i>4-5-64</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Arteriosclerosis</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>Approx 7 days</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>3-31-62</i> to <i>4-6-62</i> , that (I) (we) last saw the deceased alive on <i>4-6-62</i> , and that death occurred at <i>4:30 AM</i> , from the causes and on the date stated above.			
22a. SIGNATURE <i>G. T. Allen</i>		22b. DATE SIGNED <i>4-9-62</i>	
22c. PHYSICIAN'S NAME (Type) <i>A T ALLEN</i>		22d. ADDRESS <i>61 Orchard St</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>4-11-1962</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Macedonia</i>		23d. LOCATION (City, town, or county) (State) <i>Odenton Md</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>William Reese</i>		25a. REC'D BY REGISTRAR <i>APR 9 '62</i>	
25b. REGISTRAR'S SIGNATURE <i>William S. Hume</i>			

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04114

CENTRE OF DEATH

04114

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04149

04145

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) e. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 10 Annapolis	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS 89 Shipwright St.	
3. NAME OF DECEASED (Type or print) First Harwood Middle S. Last STRANGE		4. DATE OF DEATH Month April Day 4 Year 1962	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 11, 1888
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Accountant		10b. KIND OF BUSINESS OR INDUSTRY Gas-Electric Co.	9. AGE (In years last birthday) 73 yrs.
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Robert E. Strange		14. MOTHER'S MAIDEN NAME Amanda M. L. Plack	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes W.W.I.		16. SOCIAL SECURITY NO. 212-05-2681	17. INFORMANT Marie Stein Strange
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 527.1 Azotemia DUE TO (b) Cardiac failure, Right Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (c) Chronic obstructive Pulmonary Emphysema		INTERVAL BETWEEN ONSET AND DEATH 2 days 2 wks 1 yr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that (I) James R. Martin attended the deceased from Jan 30, 1959 to April 3, 1962 , that (I) (X) last saw the deceased alive on April 3, 1962 , and that death occurred at 1:20 AM , from the causes and on the date stated above.			
22a. SIGNATURE James R. Martin		22b. DATE SIGNED 4/4/62	
22c. PHYSICIAN'S NAME (Type) James R. Martin		22d. ADDRESS 6 Shaw St., Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF April 6, 1962	23c. NAME OF CEMETERY OR CREMATORY St Annnes Cent
23d. LOCATION (City, town or county) Annapolis		(State) Md	
24. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor-Sims		25a. REC'D BY REGISTRAR APR 8 1962	
25b. REGISTRAR'S SIGNATURE John M. Taylor-Sims		25c. REGISTRAR'S SIGNATURE John M. Taylor-Sims	

01115

CHITRAVATI DE DEVI

01115

(M)

Handwritten text in Devanagari script, appearing to be a list or record of names and dates. Some legible words include "आदि", "सं", "दिनांक", "वर्ष", "प्राप्त", "प्रमाण".

Handwritten text in Devanagari script, continuing the list or record. Some legible words include "प्रमाण", "दिनांक", "वर्ष", "प्राप्त", "प्रमाण".

Handwritten text in Devanagari script, continuing the list or record. Some legible words include "प्रमाण", "दिनांक", "वर्ष", "प्राप्त", "प्रमाण".

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04150

CERTIFICATE OF DEATH

04146

Item 12 Film 0311 4/19/62 mh

1. PLACE OF DEATH a. COUNTY A.A. MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Md. b. COUNTY A.A.	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) North Linthicum		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) North Linthicum	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 43 Old Annapolis Blvd.		d. STREET ADDRESS 43 Old Annapolis Blvd.	
3. NAME OF DECEASED (Type or print) MICHAEL SZANDROWSKI (SANDUSKY)		4. DATE OF DEATH Month 4 Day 8 Year 1962	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/14/96
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber		10b. KIND OF BUSINESS OR INDUSTRY Self Emp.	11. BIRTHPLACE (County & State, or foreign country) Europe
12. CITIZEN OF WHAT COUNTRY? Russia (Ukraine)			
13. FATHER'S NAME ?		14. MOTHER'S MAIDEN NAME ?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO. 2I7 32 8920	
17. INFORMANT Family - Same		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 782.4 DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7-8, 1962 to 4-7, 1962 that (I) (we) last saw the deceased alive on 4-7, 1962 , and that death occurred at 9:00 M, from the causes and on the date stated above.			
22a. SIGNATURE Eugene Schnitzer		22b. DATE SIGNED 4-9-62	
22c. PHYSICIAN'S NAME (Type) Eugene Schnitzer		22d. ADDRESS 3904 S. Hanover St. Balt., Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) B		23b. DATE THEREOF 4/11/62	
23c. NAME OF CEMETERY OR CREMATORY Holy Cross		23d. LOCATION (City, town or county) (State) Baltimore	
24. FUNERAL DIRECTOR'S SIGNATURE McGully - 130 E. Fort Ave.		25a. REC'D BY REGISTRAR DATE APR 13 '62	
ADDRESS		25b. REGISTRAR'S SIGNATURE Arthur L. Thomas	

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
ISM 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04147

Items 13 & 14 Film 6312 5/1/62 mh

1. PLACE OF DEATH a. COUNTY Anne Arundel		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Pasadena	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS RFD 9 Box 62	
3. NAME OF DECEASED (Type or print) Alfred Jack Thomas		4. DATE OF DEATH April 19 1962	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED	8. DATE OF BIRTH 4/16/86
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Musician		10b. KIND OF BUSINESS OR INDUSTRY Self Employed	9. AGE (In years last birthday) 76 yrs.
11. BIRTHPLACE (County & State, or foreign country) Pittsburgh, Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown Thomas		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Yes WW I		17. INFORMANT Hospital Files	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro-vascular Accident 33 IX DUE TO Conditions, if any, which gave rise to immediate cause (b) Generalized arteriosclerosis (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH about 2 wks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4-4-62 19 to 4-19-62 19, that (I) (we) last saw the deceased alive on 4-19-62 , and that death occurred at 6:50 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Aris T. Allen		22b. DATE SIGNED M.D.	
22c. PHYSICIAN'S NAME (Type) Aris T. Allen, M.D.		22d. ADDRESS 62 Cathedral Street, Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-24-62	
23c. NAME OF CEMETERY OR CREMATORY Baltimore National		23d. LOCATION (City, town or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Charles R. Law		25a. REC'D BY REGISTRAR APR 24 '62	
ADDRESS 802 Madison Ave., Balto., Md.		25b. REGISTRAR'S SIGNATURE Wm. L. Thomas	

04117

04117

Self-employed
Pittsburgh, Pennsylvania
U.S.A.

Charles R. Law 302 Madison Ave., Baltimore, Md.
Baltimore, Maryland

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 04148

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>HA. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>A.A. GENERAL Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>TRUMAN</u> Middle <u>D.</u> Last <u>VENOY</u>		4. DATE OF DEATH Month <u>4</u> Day <u>28</u> Year <u>1962</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-13-1909</u>
9. AGE (In years last birthday) <u>52</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CHAUFFEUR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>State of Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>West Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Louis W. Veno</u>		14. MOTHER'S MAIDEN NAME <u>Nancy Hatfield</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Dorothy Veno</u>		Address <u># 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac</u> <u>434.4</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>E. Linhart</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>E. Linhart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>4/20/62</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>5-2-62</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>EVON CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>BARKERSVILLE W. VA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor & Sons Annapolis, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 2 '62</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

VS. A15ME
5M 9/60

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay occurs, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
04154						04150					
1. PLACE OF BIRTH						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)					
a. COUNTY <i>Anne Arundel.</i>						a. STATE <i>Maryland.</i> b. COUNTY <i>Baltimore.</i>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					
<i>Glen Burnie.</i>						<i>Baltimore</i> 13, Md. 3V01-4					
c. LENGTH OF STAY (In months)						d. STREET ADDRESS					
<i>1 month.</i>						<i>1114 N. Kenwood Ave.</i>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
<i>1122 a Manor Nursing Home</i>											
3. NAME OF DECEASED (Type or print)						4. DATE OF DEATH		Month		Day Year	
<i>George</i> First Middle Last <i>WAGNER</i>						<i>April</i>		<i>25</i>		<i>1966</i>	
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR	
<i>M.</i>		<i>W.</i>				<i>July 5, 1897</i>		<i>64</i> yrs.		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTH PLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<i>Unknown.</i>								<i>Baltimore, Md.</i>		<i>U.S.A.</i>	
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME					
<i>Unknown</i>						<i>Unknown</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)						16. SOCIAL SECURITY NO.		17. INFORMANT			
								<i>ELEANORA M. MELVIN</i> Address <i>GRAY'S CREEK RT 2. Box 328 PASADENA, MD</i>			
18. CAUSE OF DEATH (Enter only one cause positive for (a), (b), and (c).)						INTERVAL BETWEEN ONSET AND DEATH					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)						<i>Mycardial Infarct and Pneumonia</i>					
<i>420.1</i> DUE TO						<i>Arteriosclerotic Cardio Vascular Disease.</i>					
Conditions, if any, which gave rise to immediate cause (b)											
(c) DUE TO											
cause last.											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<i>Chronic Brain Syndrome due to Generalized Arteriosclerosis</i>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY		Month, Day, Year		20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
Hour e.m. p.m.		<i>19</i>		While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<i>3/27/66</i>		<i>19</i>		<i>4/25/66</i>	
21. I certify that (I) (this hospital) attended the deceased from <i>4/25/66</i> to <i>4/25/66</i> ; that (I) (we) last saw the deceased alive on <i>4/25/66</i> , and that death occurred at <i>6</i> M, from the causes and on the date stated above.											
22a. SIGNATURE						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
<i>Lincoln M. Henry Mapp</i>						<i>20 Dean Street, Annapolis, Md.</i>		<i>4/25/66</i>			
22c. PHYSICIAN'S NAME (Type)						22d. ADDRESS					
<i>Lincoln M. Henry Mapp</i>						<i>20 Dean Street, Annapolis, Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)			
<i>BURIAL</i>				<i>4-28-62</i>		<i>Glen Haven Cemetery</i>		<i>Glen Burnie, Maryland</i>			
24. FUNERAL DIRECTOR'S SIGNATURE						ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
<i>Wm. Cook-Blight, Inc.,</i>						<i>6009 Harford Road Zone 14</i>		DATE <i>APR 27 '62</i>		<i>Arthur S. Kline</i>	

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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04155
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04151

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Friendship			c. LENGTH OF STAY IN 1b Friendship			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Friendship	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First AGNES Middle LEE Last WARD				4. DATE OF DEATH Month April Day 27 Year 19 62			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 2, 1878	
9. AGE (In years last birthday) 83 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Domestic		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME James T. Dorsey				14. MOTHER'S MAIDEN NAME Margaret Chaney			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) -----		16. SOCIAL SECURITY NO. -----		17. INFORMANT Address Mrs. Ethel Hudson Friendship, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 442X IMMEDIATE CAUSE (a) Cardio vascular senile DUE TO hyp Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 1 1962 to 4/27 1962 that (I) (we) lost saw the deceased alive on 4/26 1962 and that death occurred at 10 M, from the causes and on the date stated above.							
22a. SIGNATURE H.W. Ward				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 4/27/62	
22c. PHYSICIAN'S NAME (Type) H.W. WARD				22d. ADDRESS Friendship Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Apr. 29, 62		23c. NAME OF CEMETERY OR CREMATORY Friendship Cemetery		23d. LOCATION (City, town, or county) (State) Friendship Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Hutchins Funeral Home				ADDRESS wings, Maryland		25a. REC'D BY REGISTRAR DATE MAY 1 '62	
						25b. REGISTRAR'S SIGNATURE Arthur S. Frank	

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04121

04125

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H. W. WARD

Medical Journal House

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

04156

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04152

1. PLACE OF DEATH a. COUNTY <u>Ann. A.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Ann. A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b <u>10</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>General Hospital</u>		d. STREET ADDRESS <u>275 Calvert St.</u>	
3. NAME OF DECEASED (Type or print) <u>Lillian</u> First <u>Wardell</u> Middle <u></u> Last <u></u>		4. DATE OF DEATH Month <u>4</u> Day <u>17</u> Year <u>1962</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-31-1931</u>
9. AGE (In years last birthday) <u>30</u> yrs.		10. IF UNDER 1 YEAR Months <u></u> Days <u></u>	11. IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Archie Blunt</u>		14. MOTHER'S MAIDEN NAME <u>Eugenie Tuley</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u></u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>Ruth Blunt</u> Address <u>100 Seren Ave.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>due to Coronary Artery disease.</u> DUE TO (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Bronchial Asthma.</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>May</u> 19 <u>57</u> , to <u>Apr. 17</u> , 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>Apr. 17</u> , 19 <u>62</u> and that death occurred at <u>4</u> P.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>R. L. Richardson</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>R. L. Richardson, M. D.</u>		22d. ADDRESS <u>119 Clay Street, Annapolis, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>4-21-62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Franklin</u>		23d. LOCATION (City, town, or county) (State) <u>Wicac Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>William Reesett</u> ADDRESS <u>Annapolis, Md.</u>		25a. REC'D BY REGISTRAR <u></u> 25b. REGISTRAR'S SIGNATURE <u>William A. Turner</u>	
DATE <u>APR 24 '62</u>			

04128

04128

CERTIFICATE OF DEATH

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH
OFFICE OF THE REGISTRAR

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04157

04153

Items 1d, 13, 14 Film G311 4/23/62 mh

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis c. LENGTH OF STAY IN lb 4 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) A.A. General Hospital			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MD b. COUNTY AA c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) X Mayo MD d. STREET ADDRESS 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) CHARLES EDWIN WHEELER			4. DATE OF DEATH Month 4 Day 7 Year 1962		
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 12/13/85	9. AGE (In years last birthday) 76 yrs.	IF UNDER 1 YEAR Months 7 Days 19
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tugboat Master			10b. KIND OF BUSINESS OR INDUSTRY MASTER MARINER		
11. BIRTHPLACE (County & State, or foreign country) MAYO MD			12. CITIZEN OF WHAT COUNTRY? MAYO MD		
13. FATHER'S NAME Samuel Edwin Owens Wheeler			14. MOTHER'S MAIDEN NAME Iranna Dawson		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO			16. SOCIAL SECURITY NO. 180 14 1851		
17. INFORMANT Robert Wheeler Mayo MD			Address Mayo MD		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LOBAR PNEUMONIA DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. } DUE TO (c) 490X					INTERVAL BETWEEN ONSET AND DEATH DAYS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arterio-sclerotic cardiac vascular disease and Lymphatic Leukemia					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from August 12-30 1960 to 4/7 1962 , that (I) (we) last saw the deceased alive on 4/6/62 19 62 , and that death occurred at 4/7 1962 M, from the causes and on the date stated above.					
22a. SIGNATURE G. Chuach		M.D. G. CHUACH		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS 121 Cathedral St Annapolis MD 22b. DATE SIGNED 4/8/62	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-10-62		23c. NAME OF CEMETERY OR CREMATORY Rucker	
23d. LOCATION (City, town or county) Kratersville		23e. (State) MD			
24. FUNERAL DIRECTOR'S SIGNATURE Bernard Hardisty		ADDRESS Kratersville MD		25a. REC'D BY REGISTRAR APR 13 '62 DATE	
25b. REGISTRAR'S SIGNATURE Arthur S. Thomas					

01123

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate shall be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04158

CERTIFICATE OF DEATH

04154

1. PLACE OF DEATH a. COUNTY Anne Arundel			b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville			c. LENGTH OF STAY IN 1b 16 years 9 mos. 22 days			2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE Maryland			b. COUNTY Baltimore City			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			d. STREET ADDRESS 704 Dolphin Street			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Pauline			First Pauline			Middle Wheeler			Last Wheeler			4. DATE OF DEATH Month 4			Day 3			Year 1962					
5. SEX Female			6. COLOR OR RACE Negro			7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH July 7, 1895			9. AGE (In years last birthday) 66 yrs.			IF UNDER 1 YEAR Months Days			IF UNDER 24 HRS. Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework						10b. KIND OF BUSINESS OR INDUSTRY -----						11. BIRTHPLACE (County & State, or foreign country) Maryland						12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Harry Wheeler						14. MOTHER'S MAIDEN NAME Julia Greene																	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No						16. SOCIAL SECURITY NO. Unknown						17. INFORMANT Hospital Records						Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) Arteriosclerotic Hypertensive Cardiovascular Disease (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																		INTERVAL BETWEEN ONSET AND DEATH					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----																	
20c. TIME OF INJURY Month, Day, Year Hour e.m.----- p.m. 19						20d. INJURY OCCURRED While at work <input type="checkbox"/> Not at work <input type="checkbox"/>						20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----						20f. (City or town) ----- (County) ----- (State) -----					
21. I certify that (I) (this hospital) attended the deceased from 6/11, 1945 to 4/3, 1962, that (I) (we) last saw the deceased alive on 4/3, 1962, and that death occurred at 7:45 P.M., from the causes and on the date stated above.																							
22a. SIGNATURE <i>L. Benedict</i>						M.D. L. Benedict, M. D.						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22b. DATE SIGNED 4/4/62					
22c. PHYSICIAN'S NAME (Type) L. Benedict, M. D.						22d. ADDRESS Crownsville State Hospital, Maryland																	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL						23b. DATE THEREOF 4/7/62						23c. NAME OF CEMETERY OR CREMATORY Not Buried						23d. LOCATION (City, town or county) Baltimore Md (State)					
24. FUNERAL DIRECTOR'S SIGNATURE Marshall P. Hayes						ADDRESS 638 W. Delaware St						25a. REC'D BY REGISTRAR APR 6 '62						25b. REGISTRAR'S SIGNATURE Arthur L. Evans					

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04155

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN lb <u>11 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Anne Arundel General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Pearl</u> First Middle Last <u>WIDENER</u>		4. DATE OF DEATH <u>April 13 1962</u> Month Day Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 12, 1893</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		9b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>	
10a. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>		10b. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
11. FATHER'S NAME <u>A. B. Widener</u>		12. MOTHER'S MAIDEN NAME <u>Elizabeth Wilson</u>	
13. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>---</u>		14. SOCIAL SECURITY NO. <u>---</u>	
15. INFORMANT <u>Hospital records</u>		Address <u>---</u>	
16. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage right frontal lobe, due to</u> DUE TO (b) <u>Arteriosclerosis, cerebral vessels, severe</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>---</u> DUE TO (c) <u>---</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>????</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>---</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>---</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>---</u>		20f. (City or town) (County) (State) <u>---</u>	
21. I certify that (I) (<u>Hutchinson</u>) attended the deceased from <u>Apr. 2, 1962</u> to <u>Apr. 12, 1962</u> , that (I) (<u>yes</u>) last saw the deceased alive on <u>Apr. 12, 1962</u> , and that death occurred at <u>2:45 AM</u> on <u>Apr. 12, 1962</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Richard I. Hochman</u> M.D.		22b. DATE SIGNED <u>4/13/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Richard I. Hochman, M.D.</u>		22d. ADDRESS <u>59 Franklin St., Annapolis, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Apr. 15, 1962</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Harmony Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Nr. Owings, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Hutchinson Funeral Home</u>		24b. ADDRESS <u>Owings, Maryland</u>	
25a. REC'D BY REGISTRAR <u>APR 18 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kenna</u>	

04155

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CENTRAL OF TEXAS



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Richard W. Helms

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FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

04160 MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04156

1. PLACE OF DEATH a. COUNTY Galesville Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Galesville			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Galesville		c. LENGTH OF STAY IN 1b 20 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Galesville		d. STREET ADDRESS 1	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last James Edward Williams Jr.				4. DATE OF DEATH Month Day Year April 9 1962			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 21 1941	9. AGE (In years at birthday) 20	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. 19 62
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STUDENT		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Annapolis Md		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME James Edward Williams Sr.				14. MOTHER'S MAIDEN NAME Ethel Hazard			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220360655		17. INFORMANT Dorothy Smith		Address Galesville	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bullet wound left temple - DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Self inflicted rifle bullet					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 4-9-1962 8:30 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Emily H. Wilson				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Emily H. Wilson M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county) 4-1062			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/11/62		22c. NAME OF CEMETERY OR CREMATORY 203KER		22d. LOCATION (City, town, or country) (State) Galesville Md	
23. FUNERAL DIRECTOR Bernard Hurdant				24a. REC'D BY REGISTRAR DATE APR 17 '62		24b. REGISTRAR'S SIGNATURE Arthur S. Hurdant	

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VS. A15ME
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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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FOR STATE
HEALTH DEPT.
Necessary, 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARY AND MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09499

1. PLACE OF DEATH e. COUNTY Anne Arundel		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First SAMUEL Middle WILLIAMS Last WILLIAMS		4. DATE OF DEATH Month April Day 29 Year 1962	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 65 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)	
10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes give number and dates of service)	
17. INFORMANT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Peter W. Rieckert, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> M.D. Medical Investigator x DATE SIGNED 4/30/62	
22a. BURIAL (CREMATION) REMOVAL (Specify)	22b. DATE THEREOF 8.28.62	22c. NAME OF CEMETERY OR CREMATORY V. P. and W. School	22d. LOCATION (City, town, or country) (State) Baltimore, Md.
23. FUNERAL DIRECTOR NAME (Type) John M. Taylor & Sons--147 Gloucester St. ADDRESS Annapolis, Md.		24a. REC'D BY REGISTRAR DATE AUG 31 '62	
24b. REGISTRAR'S SIGNATURE Arthur S. Evans			

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
04161						04158					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)					
a. COUNTY						e. STATE					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)						f. COUNTY					
c. LENGTH OF STAY IN						g. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)						h. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
1. Anne Arundel						2. Maryland					
3. Millersville						4. Linthicum Heights					
5. Knollwood Manor Nursing Home						6. 419 Hawthorne Road					
3. NAME OF DECEASED (Type or print)						4. DATE OF DEATH					
First Middle Last						Month Day Year					
JOHN W. WILSON						4th April 1962					
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR	
Male		White				16th Oct. 1871		90 yrs.		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country)			
Machinist (ret.)				Baugh Chem. Co.				Oriole, Maryland			
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
U.S.A.				James M. Wilson				Margaret Wallace			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. (If yes give war or dates of service)				17. INFORMANT Address			
no				212-12-5204				Mrs. Carolyn Waters Same As #2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										4-5 yr	
443X DUE TO										10 yr	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
(b) Cardio-vascular Disease											
(c) Arterio-sclerosis & Hypertension											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
19											
21. I certify that (I) (this hospital) attended the deceased from 1948 to 4/06/62, 19....., that (I) (we) last saw the deceased alive on 4/06/62, 19....., and that death occurred at.....M, from the causes and on the date stated above.											
22a. SIGNATURE						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED		
Chas. L. Ball Jr.						M.D.			4/6/62		
22c. PHYSICIAN'S NAME (Type)						22d. ADDRESS					
						Linthicum Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City, town or county) (State)	
Burial				7th Apr '62		Meadowridge Men. Park				Howard Co., Md.	
24. FUNERAL DIRECTOR'S SIGNATURE						ADDRESS			25a. REC'D BY REGISTRAR		
Richard T. Singleton						Glen Burnie, Md.			25b. REGISTRAR'S SIGNATURE		
						DATE			APR 9 '62		
									Arthur S. Kraus		

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TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
ATTENDING PHYSICIAN: After this certificate has been signed by the attending physician and completely filled in, it may be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04162 CERTIFICATE OF DEATH 04159

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN lb <u>2 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Anne Arundel General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Henry</u>		4. DATE OF DEATH Month <u>April</u> Day <u>24</u> Year <u>1962</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5/18/94</u>	
9. AGE (In years last birthday) <u>67</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Disabled Veteran</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>*****</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Edna Wright-94 Clay St. Annapolis, Md.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive Heart Failure & Pulmonary Edema</u> 410X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocardial Infarction</u> DUE TO (c) <u>Mitral & Coronary Heart Disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>2 days</u> <u>years</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>February 18, 1962</u> to <u>April 24, 1962</u> , that (I) (we) last saw the deceased alive on <u>April 24, 1962</u> , and that death occurred at <u>8:30 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Faye W. Allen</u>		22b. DATE SIGNED <u>4/27/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. Faye Allen</u>		22d. ADDRESS <u>Cathedral St., Annapolis, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>April 29-62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Broadneck</u>		23d. LOCATION (City, town or county) (State) <u>A.A.Co. Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>C.E. HICKS 111 Annapolis, Maryland</u>		25a. REC'D BY REGISTRAR DATE <u>MAY 2 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thoma</u>			

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biochemical data

1. The first step is to identify the problem or question that needs to be answered. This involves understanding the context and the specific requirements of the task.

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 10 Annapolis					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Anne Arundel General Hospital						d. STREET ADDRESS 1 100 Chesapeake Ave.					
3. NAME OF DECEASED (Type or print) John L WRIGHT						4. DATE OF DEATH Month Day Year April 12 1962					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH June 7, 1908		9. AGE (In years last birthday) 53 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman Ret.				10b. KIND OF BUSINESS OR INDUSTRY Retail Store				11. BIRTHPLACE (County & State, or foreign country) Texas			
13. FATHER'S NAME Ernest Wright						14. MOTHER'S MAIDEN NAME Lillian Piper					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 220-10-7211		17. INFORMANT Mrs. Hazel Wright- Wife- Same as #2					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 023X DUE TO Coronary Occlusion Conditions, if any, which gave rise to immediate cause (b) Lucid Heart Disease (c) DUE TO cause fest. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 18 YEARS						INTERVAL BETWEEN ONSET AND DEATH 10 HOURS					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (I) (Successor) attended the deceased from July 1952 to Apr. 12, 1962, that (I) saw the deceased alive on Apr. 12, 1962, and that death occurred at 6:25 PM from the causes and on the date stated above.											
22a. SIGNATURE Edward S. Beck M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) Edward S. Beck, M.D.						22d. ADDRESS 71 Franklin St., Annapolis, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF April 16, 62		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery				23d. LOCATION (City, town or county) Annapolis, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home						25a. REC'D BY REGISTRAR ADDRESS Annapolis, Maryland					
						25b. REGISTRAR'S SIGNATURE		DATE APR 17 '62			

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